STATE INTERAGENCY COORDINATING COUNCIL ON EARLY INTERVENTION

Together, we make a difference!

DEPARTMENT OF SOCIAL SERVICES
SACRAMENTO

FEBRUARY 28 & MARCH 1, 2013

STRATEGIC PLANNING

Interagency Coordinating Council on Early Intervention
1600 Ninth Street, Room 330, Sacramento, CA 95814
(916) 654-1590 • FAX (916) 654-3255 • TDD 654-2054

DATE: FEBRUARY 7, 2013

TO: ICC MEMBERS AND COMMUNITY REPRESENTATIVES

SUBJECT: FEBRUARY 28, and March 1, 2013 ICC MEETING

The following is information regarding the February 28 and March 1, 2013 ICC Strategic Planning Meeting which will be held at the Department of Social Services in Sacramento. Directions, parking, and airport shuttle information to Department of Social Services are included in this notice. WebEx connection information for the meeting is also included.

Individuals who require accommodations in order to attend the meeting (i.e., assistive listening devices, interpreting services, material in alternative format) should notify Patric Widmann at (916) 654-3722 or pat.widmann@dds.ca.gov or call (916) 654-2054 (TDD) ten days in advance of the meeting. The meeting location is accessible to individuals with disabilities. Visit our website at www.dds.ca.gov/earlystart to view previous ICC meeting minutes and additional information about California Early Start.

PROPOSED AGENDA

DATE: THURSDAY, FEBRUARY 28, 2013
TIME: 10:00 A.M. - 4:30 P.M.

LOCATION: Department of Social Services
744 P Street, OB-9, Room 1804
Sacramento, CA 95814

Executive Committee Strategic Planning Meeting:
The ICC Executive Committee will review and discuss ICC planning including unfinished standing committee business, ICC priorities and standing committee structure

DATE: FRIDAY. MARCH 1, 2013
TIME: 8:30 A.M. - 1:30 P.M.

LOCATION: Department of Social Services
744 P Street, OB-8, Room 235/237
Sacramento, CA 95814

Full ICC Strategic Planning Meeting:
The ICC will hear reports from agency representatives and receive public input. The ICC will review the Strategic Plan developed by the Executive Committee and will vote on Action Item: *Speech and Language Pathology Assistants (SLPA) Best Practice Guidance for Early Intervention.* Future special presentations will also be discussed.

INFORMATION TO ASSIST YOU WITH TRAVEL ARRANGEMENTS:

MEETING LOCATION: California Department of Social Services
744 P Street
Sacramento, CA 95814

Special Security Instructions: When entering the building please check-in with the security counter to register and receive an entry pass. Please have proper photo ID, and ask for the State ICC Meeting 2nd floor

Please see Page 1 of this notice for building and room numbers

Lodging Information: Information may be obtained by contacting Anastacia Byrne-Reed, the ICC Coordinator at (916) 654-1590 or AReed2@dds.ca.gov.

I-5 North:
Take I-5 North. Take Q Street Exit. Ramp will put you on Q Street. California Department of Social Services is on P Street between 7th & 8th Streets

I-5 South:
Take I-5 South. Take Q Street Exit, ramp will put you on Q Street. The California Department of Social Services is on P Street between 7th and 8th Streets

FROM HWY 99 North:
Take Business 80/Capital City Freeway split toward San Francisco. Take I-5 North toward Redding. Take Q Street Exit, ramp will put you on Q Street, California Department of Social Services is on P Street between 7th and 8th Streets.

FROM HWY 50:
Take the Business 80/Capital City Freeway split toward San Francisco. Take I-5 North toward Redding. Take Q Street Exit, ramp will put you on Q Street, California Department of Social Services is on P Street between 7th and 8th Streets.

PARKING:
Lot Parking: See $8.00 all day parking lot on Q & 7th Street, on 7th Street turn left in the alley; please pay close attention to all signs and park **ONLY** in lot where ticket was purchased.

Street Parking: There are 10 hour meters on streets Q, R, 7th and 8th; please be advised meters only accept quarters at 12 minutes each. You will need to have $8 in quarters to reach maximum of 10 hours.

VAN: Super Shuttle
Reservations: 1-800-BLUE-VAN

Super Shuttle is located directly outside the baggage claim area at each terminal. Reservations are not required unless for large parties or private charters. Go to the Super Shuttle service center, and purchase either a round-trip or a one way ticket.

WebEx Instructions for joining
the Executive Committee and ICC General Meetings:

For those who cannot participate in person, the ICC Executive Committee Strategic Planning Meeting (Thursday, February 28, 2013 at 10:00A.M.) and the ICC General Strategic Planning Meeting (Friday, March 1, 2013 at 8:30a.m.) will be offered in the WebEx format. **Participants need to call into the teleconference line AND login and to view any online materials.**

To join the meetings by phone:

Dial-in number: (877) 413-2826
Conference code: 7166875684

To login to the WebEx online conference site
go to https://wested.webex.com.

Once logged in, you will see a list of meetings for that day. Select the meeting name (ICC Executive Committee Meeting, February 28, 2013, or ICC Teleconference Meeting, March 1, 2013. There is no password; just click on the link. Enter your name, and you will access the WebEx conference.

Please contact Debbie Pollard at (916) 492-4011, or dpollar@wested.org, with any logistical problems or issues.

CALIFORNIA INTERAGENCY COORDINATING COUNCIL
"Together We Make A Difference"

EASY TIPS for SUCCESSFUL WEBEX and CONFERENCE CALLS*

PARTICIPANT COURTESIES

1. **Use a landline if possible for the least static interference.**

2. **Avoid cellular and cordless phones.** The potential static and poor or broken connections reduce the sound quality for all conference call participants. If you must use a cell phone, find a quiet location with excellent reception and limit moving around during the call.

3. **Know your phone's features and how to use them.** Don't wait until the call to figure them out.

4. **Turn off call waiting.** It's very disruptive to the call. Most call waiting features can be deactivated by pressing 70# or *70 before dialing the conference number. (Check with your carrier.)

5. **Use the speaker feature on your phone only if the room is quiet and others in the room are participating on the call with you.** Speakerphones can add to the overall noise of the teleconference and create a hollow sound on the call.

6. **Choose a quiet location.** Avoid background noises such as a radio, TV, pets, or side conversations with others.

7. **Stay focused and participate on the call.** Avoid using this time to answer email, eat, clear off your desk, file papers, or talk to others.

8. **Be on time.**

9. **Introduce yourself when you join the call.** If you join the call late, wait for a break in the conversation to announce that you've joined or until the moderator asks who joined.

10. **Introduce yourself each time you speak.** Not everyone will be familiar with your voice.

11. **Mute your phone (*6) if you are not participating at the time, need to talk to someone else, or need to leave the call for any reason. Unmute your phone (#6) when you're able to return to the call.**

12. **Never put the call on hold.** Either mute your phone (*6) and unmute your phone (#6) to rejoin. Hang up and call in again if you must leave the call**.**

FACILITATOR/CHAIRPERSON COURTESIES

1. **Be familiar with the audio controls.**
2. **Start—and end—at the scheduled time.**
3. **Have an agenda—preferably one that's been distributed prior to the conference.**
4. **Identify yourself when you first connect to the conference call.**
5. **Identify yourself each time you speak.** Others may not know your voice. Speak clearly and at a moderate speed.
6. **Take roll call at the conference start so that everyone knows who is involved and listening.**
7. **Review the rules of etiquette and ask that each participant identify him or herself before speaking.**
8. **Allow only one individual to speak at any given time during the conference.**
9. **As much as possible, when appropriate, address questions to individuals by name.**
10. **Mute the microphone or speakerphone (*6) if you must speak to others in the room with you during the conference. Unmute by pressing #6.**
11. **Address agenda items in their specified order.**

*Thank you to the Family Resource Center Network of California, the source for many of these tips, for sharing its teleconference etiquette.

Interagency Coordinating Council On Early Intervention

Mission Statement

The mission of the ICC is to promote and enhance a coordinated family service system for infants and toddlers, birth to three years, who have a developmental delay or disability, and their families, utilizing and encouraging a family centered approach, family-professional partnerships, and interagency collaboration.

The History of the ICC

California has a long history of providing early intervention services to infants and toddlers, ages birth to 3 years old, and their families. In the 1960s and 1970s, special education services for infants and toddlers were provided in public schools and funded through various local, state and federal sources. With the advent of the Lanterman Developmental Disabilities Services Act in 1982, California demonstrated its support of young children for prevention and early intervention services for infants with developmental disabilities through the regional center system. This was a huge effort and viewed as a major investment in California's children.

In 1988, the first Interagency Coordinating Council (ICC) was developed to provide advice and assistance to the Department of Developmental Services regarding implementation of a coordinated early intervention system in California. In 1993, after five years of state and local planning activities in preparation for full implementation of Part C of the Individuals with Disabilities Education Act (IDEA), the Governor signed the California Early Intervention Services Act (CEISA: Title 14, Government Code, Section 95000 et seq.). CEISA established state authority to enhance California's early intervention service system to meet the new federal requirements under Part C. It was CEISA that assigned DDS as lead agency in collaboration with California Department of Education (CDE). Other collaborative partners involved in the ICC include Department of Mental Health (DMH), Department of Social Services (DSS), Department of Alcohol & Drug Programs (DADP), Department of Managed Healthcare (DMHC), and First 5 of California.

Although the early intervention landscape has changed over the years in California, the ICC has continued to follow and advise and assist DDS on the state of the early intervention community. The changes have included amendments to CEISA which included the addition of provision of family support services by Early Start Family Resource Centers (FRCs) which include, but are not limited to, parent-to-parent support, information dissemination and referral, public awareness, family-professional collaboration activities and transition for families. CEISA also clarified state coordination and collaboration with families and communities, service coordinator competencies and caseload size, evaluation and assessment, parent rights, referral to local FRCs and monitoring efforts. Lastly, CEISA was also amended to clarify that the Part C program is based on existing systems and that regional centers must comply with the Lanterman Developmental Services Act including regulations related to vendorization and rate setting as long as the application of state law does not conflict with early intervention statute.

INTERAGENCY COORDINATING COUNCIL
FEBRUARY 2013

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Additional materials can be found at:

http://www.dds.ca.gov/EarlyStart/ICCOverview.cfm

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STATE INTERAGENCY COORDINATING COUNCIL
THURSDAY, FEBRUARY 28, 2013

Strategic Planning Meeting..…….....……0:00 a.m. – 4:30 p.m.

FRIDAY, MARCH 1, 2013
AGENDA

1. Introductions and Announcements……8.30 a.m.….Theresa Rossini, Acting Chair
2. Agenda Review……...Theresa Rossini, Acting Chair
3. Approval of November 16, 2012 Minutes……Theresa Rossini, Acting Chair
4. Chair's Report……..Theresa Rossini, Acting Chair
5. ICC Staff Report……..…Anastacia Byrne-Reed
6. ICC Member Recruitment Update……Theresa Rossini, Acting Chair
7. Action Item:
   Speech & Language Pathology Assistant Best
   Practices Guidelines for Early Intervention……..…Elaine Fogel Schneider
8. Strategic Plan: ICC Priorities & Committee
   Structure……..Cheryl Treadwell, Facilitator
9. Public Input……...10:00 a.m. ……...Interested Parents & Members of the Public
10. Family Resource Center Network of CA Report……..Linda Landry
11. Agency Reports:
    - Department of Developmental Services…….Don Braeger
    - Department of Social Services……Cheryl Treadwell
    - Department of Health Care Services…….... Jill Abramson, M.D.
    - Department of Managed Health Care……Susan Burger
    - Department of Public Health……Vacant
    - Department of Alcohol & Drug Programs…… .Vacant
    - Department of Mental Health……..……Vacant
    - First 5 California…….Renee Hawkins
    - California Department of Education-Special Education…….Vacant
    - California Department of Education
      -Office of Homeless Education……Leanne Wheeler
12. Other Business……..……Theresa Rossini, Acting-Chair
13. Adjournment ……1:30 p.m…….…….....Theresa Rossini, Acting-Chair

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Full ICC Roster Information can be found at:
http://www.dds.ca.gov/EarlyStart/ICCRosters.cfm

ICC STAFF CHECKLIST & DUE DATES
2013 DEADLINES FOR ICC MEETING MATERIALS

ICC MEETING ACTIVITY ALL MATERIALS ARE SUBMITTED TO ANASTACIA BYRNE-REED (AREED2@DDS.CA.GOV) AND/OR PATRIC WIDMANN (PAT.WIDMANN@DDS.CA.GOV)	2013 MEETING DATES			
	FEBRUARY 28 & MARCH 1	MAY 16 & 17	SEPTEMBER 19 & 20	NOVEMBER 14 & 15
ALL MINUTES (PRIOR MEETING NOTES) & DOCUMENTS (This includes all minutes and notes, handouts, work plan updates, agendas, electronic reports from each Department) **2 WKS AFTER ICC**	**12/03/2013**	**03/15/2013**	**05/31/2013**	**11/29/2013**
DEVELOPMENT OF ICC/EC AGENDAS: **45 DAYS PRIOR TO ICC**	**01/18/2013**	**04/02/2013**	**08/05/2013**	**10/02/2013**
MASTER CALENDAR ITEMS	**01/18/2013**	**04/02/2013**	**08/05/2013**	**10/02/2013**
ACTION ITEMS (30 DAY NOTICE!!)	**01/28/2013**	**04/16/2013**	**08/19/2013**	**10/14/2013**
PUBLIC NOTICE TO DDS COPY CENTER/Posted on DDS website **NO LATER THAN 30+5 DAYS PRIOR TO ICC**	**01/28/2013**	**04/16/2013**	**08/19/2013**	**10/14/2013**
PACKET DUE DATES: Final Packet Preparation • Don's Message • Final ICC minutes and agenda • Final EC minutes and agenda **1 WK PRIOR TO COMPLETED PACKET**	**01/28/2013**	**04/16/2013**	**08/19/2013**	**10/14/2013**

ACTION ITEM

ACTION ITEM DETAIL SHEET
STATE ICC

Committee
___ Quality Service Delivery Systems
___ Public Awareness
___ Integrated Services and Health
___ Family Resources and Supports
_X_ Executive Committee

Item
_X_ Action
____ Consent
____ Discussion
____Information

Date: November 16, 2012
To: ICC
From: Executive Committee

Title
Speech & Language Pathology Assistants Best Practice Guidelines for Early Intervention Services

Background/Discussion
Currently, there is no guidance within regulation that dictates the appropriate use of Speech and Language Pathology Assistants (SLPAs) in the field. This lack of clear guidance has created uncertainty on the appropriate use of SLPAs in the regional center system and the Early Start community at large. The *Speech & Language Pathology Assistants Best Practice Guidelines for Early Intervention Services* was developed as a recommended best practices tool for use by the Department of Developmental Services and regional center system to clarify the proper use of SLPAs; therefore, maximizing SLPAs to their full potential.

Recommendation
Approve best practices.

Possible Actions
1. Approve
2. Approve with amendments
3. Reject

Speech Language-Pathology Assistants

Guidelines for Early Intervention Services

The following information was obtained from the California Business Code, Title 16, and ASHA Position Statement 2004. Please see Sources listed at the end of this document.

A Speech Language Pathology Assistant (SLPA) has met the requirements set forth by the California Business and Professions Code for Speech-Language Pathology Assistants. To be eligible for registration by the Board as a SLPA, the applicant must possess the following qualifications:

- An associate of arts or science degree from a SLPA program accredited by the Accrediting Commission of Community and Junior Colleges, Western Association of schools and Colleges, and approved by the Board or evidence of completion of a bachelor's degree program in speech pathology or communication disorders. (For further detail on the associate and bachelor degree requirements refer to Title 16 CCR Section 1399.170.11).

All SLPA's working in the field of early intervention shall embrace the Foundational Principles for all Early Intervention Team Members

These foundational principles reflect core beliefs, values and the shared vision and intent of IDEA, Part C and the California Early Start service system.

1. Practices shall be family-centered.
2. Practices shall be relationship-based.
3. Practices shall be culturally responsive.
4. Practices shall be collaborative and interdisciplinary.
5. Practices shall be responsive to child developmental risk and protective factors.
6. Practices shall adhere to professional and ethical standards.

Duties that the SLPA's are able to perform

The SLPA may provide direct treatment assistance to children and families under the supervision of a speech-language pathologist in the child's natural environment to the maximum extent appropriate unless there is a justification in the IFSP stating why the early intervention service will not be provided in the natural environment.

The SLPA is considered a Specialized Consultant Assistant in the Early Start Personnel Model.

1. Conducting speech-language screening, without interpretation, and using age-appropriate screening protocols developed by the supervising SLP (Speech Language Pathologist).
2. Following and implementing documented treatment plans or protocols developed by a supervising SLP.
3. Documenting progress toward meeting established child and family outcomes and reporting the information to a supervising SLP.

4. Assisting a SLP during assessments, including, but not limited to, assisting with formal documentation, preparing materials, and performing clerical duties for a supervising SLP.
5. When competent to do so, as determined by the supervising SLP, acting as an interpreter for non-English speaking families.
6. Scheduling activities and preparing charts, records, graphs, and data.
7. Performing checks and maintenance on equipment including, but not limited to, augmentative communication devices.
8. Assisting with speech-language pathology research projects, in-service training, and family or community education.

SLPA supervision

The SLPA is supervised by the licensed (and/or credentialed) speech-language pathologist under the following definitions of supervision:

"Direct Supervision" means on-site observation and guidance by the supervising speech-language pathologist while a clinical activity is performed by the speech-language pathology assistant.

"Immediate Supervision" means the supervising speech-language pathologist is physically present during services provided to the child and family by the speech-language pathology assistant.

"Indirect supervision" means the supervising speech-language pathologist is not at the same location or physical space or in close proximity to the speech-language-pathology assistant, but is available to provide supervision by electronic means. Indirect supervision activities performed by the supervising speech-language pathologist may include but are not limited to, demonstration, record review, review and evaluation of audio or video-taped session, interactive television, and supervisory conferences that may be conducted by telephone or electronic mail.

"Supervision" means the provision of direction and evaluation of the tasks assigned to a speech-language pathology assistant. Methods for providing supervision include direct supervision, immediate supervision, and indirect supervision.

Early Intervention duties of a SLPA that require specific supervision

Types of supervision required for duties performed by a speech-language pathology assistant in early intervention include:

1. Duties performed by the SLPA that require immediate supervision may include, but are not limited to, any direct activity with the child and family involving medically fragile infants or toddlers. In such instances, the SLPA shall act only under the direction of the supervisor.
2. Duties performed by the SLPA that require direct supervision may include but are not limited to, any new screening or treatment activity that the assistant has been trained to perform by the supervisor, but has not yet been performed by the SLPA in direct care.
3. Duties performed by the SLPA under indirect supervision are provided in the child's natural environment unless a justification is provided and may include, but are not limited to, the following:

a. Screening or treatment activities where the supervisor has previously given instruction as to how to perform the task, has observed the assistant in the conduct of these activities, and is satisfied that the activities can be competently performed by the SLPA, i.e. imitation, turn-taking routines, following directions, labeling, generalization or carryover activities.
b. Clerical tasks such as record keeping, materials preparation, scheduling, equipment maintenance, and
c. Other non-client care activities.

Percentage of supervision

During the initial 90-Days:

The SLP will provide supervision at least 30% direct and indirect weekly of the SLPA's workweek, for the first 90 workdays. Direct supervision should be no less than 20%. Indirect supervision should be no less than 10%.
The supervising SLP will include early intervention modeling and strategies for the SLPA that will support their work with young children and families receiving early intervention services within the SLPA's scope of practice.

After the initial 90-days:

Supervision may be adjusted. The minimum is 20% supervision weekly of the SLPA's workweek, with no less than 10% being direct supervision.

Supervision days and time of day may be alternated to ensure that all children and their families received some direct contact with the SLP at least once every 2 weeks.

The supervising SLP co-signs all formal documentation and informal progress notes.

The supervising SLP will provide continued mentorship and modeling for the SLPA in the principles of providing early intervention services for young children and families.

Activities, duties, and functions outside the scope of responsibilities of a SPLA

A SLPA **may not** conduct evaluations, interpret data, alter treatment plans, or perform any task without the express knowledge and approval of a supervising speech-language pathologist

(a) Participate in parent conferences, case conferences, or inter-disciplinary team conferences without the supervising speech-language pathologist or another speech-language pathologist being present;

(b) Provide counseling or advice to a family which is beyond the scope of the /infant-toddler's treatment;

(c) Sign any documents in lieu of the supervising speech-language pathologist, i.e., treatment plans, client reimbursement forms, or formal reports;

(d) Discharge the infant or toddler from services;

(e) Make referrals for additional services;

(f) Unless required by law, disclose confidential information either orally or in writing to anyone not designated by the supervising speech-language pathologist;

(g) Represent himself or herself as a speech-language pathologist; and,

(h) Perform procedures that require a high level of clinical acumen and technical skill, i.e., vocal tract prosthesis shaping or fitting, vocal tract imaging, and oropharyngeal swallow therapy with bolus material.

NOTE: Authority Cited: Sections 2531.95 and 2538.1(a), Business and Professions Code. Reference Cited: Section 2538.1(b)(3), Business and Professions Code.

Continuing education

The supervising SLP is required to have 6 hours of continuing education in supervision training prior to commencement of supervision. Following the initial 2-year period, 3 hours in supervision training are required every 2 years.

The SLPA is required to have 12 hours of continuing education every 2-year period (state/regional workshops, formal in-service presentations, and/or independent study).

Sources

American Speech-Language and Hearing Asssociation. (2004). *Guidelines for the training and supervision of speech-language pathology assistants (Guidelines)*. http://www.asha.org/docs/html/GL2004-00054.html

American Speech-Language and Hearing Asssociation. (2004). *Training, use, and supervision of support personnel in speech-language pathology (Position Statement)* www.asha.org/policy

California Speech-Language Pathology and Audiology Board.(2011). *Excerpts from the California Business and Profession Code of Speech-Language Pathology Assistants.* http://www.slpab.co.gov/applicants/assistant.shtml

Qualified Personnel Committee of the California Interagency Coordinating Council on Early Intervention, the California Early Start Personnel Manual Work-group and the California Early Start Personnel Manual Stakeholder Group. (2010). *Early Start Personnel Manual.* Sacramento, CA: WestEd Center for Prevention and Early Intervention.

Title 16 California Code of Regulation (CCR), Sections 1399.170 - 1399.170.20.1

GENERAL MEETING MINUTES

OF NOVEMBER 16, 2012

DRAFT-TO BE APPROVED

INTERAGENCY COORDINATNG COUNCIL ON EARLY INTERVENTION
TELECONFERENCE
GENERAL COUNCIL MEETING

Friday, November 16, 2012

MEMBERS PRESENT
Theresa Rossini,* Acting Chair
Don Braeger, Designee for the Director (DDS)
Arleen Downing, M.D.
Gretchen Hester*
Linda Landry*
Marie Kanne Poulsen, Ph.D
Elaine Fogel Schneider, Ph.D
Cheryl Treadwell, Designee for the Director (DSS)
Galynn Thomas, Designee for Jill Abramson (DHCS)

MEMBERS ABSENT
Susan Burger, Designee for the Director (DMHC)

OTHERS PRESENT
Anastacia Byrne-Reed,* ICC Coordinator, DDS
Angela McGuire,* WebEx Host, WestEd
Carolyn Walker, ICC Recorder, WestEd
Patric Widmann, ICC Supervisor, DDS

Refer to Attachment A for a list of other attendees.

*Parent

CALL TO ORDER
Theresa Rossini called the meeting to order at 8:30 a.m.

OPENING ROLL CALL
WestEd took the roll call.

INTRODUCTIONS AND ANNOUNCEMENTS

Theresa Rossini called members' attention to muting their lines and indicated the meeting agenda begins on page 1 of the packets.

AGENDA REVIEW

The agenda was approved with the following revisions:

- The special presentation planned for today by Dr. Robin Hansen of the UC Davis MIND Institute was cancelled due to an emergency and will be rescheduled.
- Prevention Resources and Referral Services (PRRS) will be the subject of the special presentation.
- The format of the February 2013 meeting and strategic planning were added to Other Business.

APPROVAL OF SEPTEMBER 7, 2012 MEETING MINUTES

The minutes were approved with the following revision:

Add to the Executive Committee Report that a lively discussion ensued about whether the November 2012 meeting should occur if it could not be face-to-face.

Theresa requested, and DDS agreed, that meeting minutes should go to the Chair for review before being distributed to the membership at large, as has always been the case in the past.

EXECUTIVE COMMITTEE REPORT

Marie Kanne Poulsen thanked ICC's partners at DDS and WestEd for their contributions to the Executive Committee. Marie reported the following:

- Elaine Fogel Schneider shared that the Speech and Language Work Group is reviewing feedback it received on its *Guidelines for Speech Language Pathology Assistants for Early Intervention Services* and will present the guidelines to the ICC as an action item at the February 2013 meeting.
- Don Braeger gave the DDS status update, focusing on travel for meetings and the Part C application.
- Don introduced DDS' Assistant Deputy Director, Jim Knight, who informed the Council that they would be able to meet face-to-face for the February 2013 meeting and that it would be important to have a quorum present.
- The Under-Representation and Outreach Workgroup has completed the recruitment packet which has been disseminated to ICC members and community representatives. The recruitment packet is on the DDS website.
- Marie led a discussion on the need for proactive recruitment of parents and professionals, particularly those with children under the age of 12 and under the age of 6, as new ICC members in order to be compliant with federal requirements.

- Marie stressed the importance of having the Governor's Office take responsibility for making appointments to the ICC. Refer to the Executive Committee minutes for detail on recruitment efforts.

CHAIR'S REPORT

Theresa thanked members for their commitment in attending teleconference meetings. She sent an email to DDS Assistant Deputy Director Jim Knight thanking him for attending yesterday's executive committee meeting and invited him to attend the February 2013 meeting.

ICC STAFF REPORT

Anastacia Byrne-Reed reported that the revised ICC web page is with DDS management for review. Feedback from the ICC membership largely included fine-tuning of the language and requests for more diversity in the photos. DDS may have the new website completed by March 2013.

On October 5, 2012, the Technical Assistance & Dissemination (TA&D) Network hosted a webinar to educate State Advisory Panels and Interagency Coordinating Councils on results-driven accountability (RDA). The IDEA requires that the primary focus of IDEA monitoring be on improving educational results and functional outcomes for children with disabilities and ensuring that states meet the IDEA program requirements. Ruth Ryder, Deputy Director of the Office of Special Education Programs (OSEP), presented information about this new approach and answered questions on RDA. Stacie will distribute the link to the archived webinar for those interested.

FAMILY RESOURCE CENTERS NETWORK OF CALIFORNIA REPORT

Linda Landry reported the following:

- The Family Resource Centers Network of California (FRCNCA) Steering Committee met monthly via conference call. Under the auspices of the Capacity Building Grant from Strategies, FRCNCA began a review of its strategic plan that was developed in 2004. They are reviewing the status of the goals and were pleased to be able to mark "Become voting member of the ICC" as a completed goal.
- Outreach and collaboration activities included participation at the Early Start Technical Assistance Network, UC Davis MIND Institute Center for Excellence in Developmental Disability Consumer Advisory Committee, the UCLA Tarjan Center University Center for Excellence in Developmental Disability Consumer Advisory Committee, Lanterman Coalition, California Network of Family Strengthening / Support Networks Training and Technical Assistance Collaborative, California Standards for Family Strengthening and Support Committee, California Family Resource

Association, California Strengthen Families Roundtable and ARC California Board of Directors.

- The FRCNCA is participating in the California Employment Consortium for Youth and Young Adults with Intellectual and Other Developmental Disabilities .
- The FRCNCA continued the implementation of PRRS.
- A Southern California training was held in San Diego for FRCNCA Regions 5, 6, 7, 8 and 9 with over 30 PRRS staff representing 11 FRCs in attendance.
- The first Northern California training for FRCNCA Regions 1, 2, 3 and 4 was held in Sacramento at the Nonprofit Innovation Center where the FRCNCA is housed. Twenty-four PRRS staff, representing 12 FRCs, were in attendance.
- Monthly webinars are being held to provide training and technical assistance.
- Bi-monthly PRRS calls continue to be held for all PRRS staff and provide a forum to ask questions, raise issues, express needs or make comments on general program, budget, data, outreach, training or other items related to PRRS.
- Individualized technical assistance and training is ongoing.
- The *PRRS First Year Highlights* handout and PowerPoint were presented at the Southern and Northern California regional meetings, and a webinar was held for those unable to attend.
- FRCNCA continues to seek additional funding sources to maintain the coordination of the network.

ACTION ITEM: PROPOSED ICC MEETING SCHEDULE FOR 2013

Dates proposed for ICC's 2013 meetings were unanimously approved:

February 21 and 22, 2013
May 16 and 17, 2013
September 19 and 20, 2013
November 14 and 15, 2013

AGENCY REPORTS

Department of Developmental Services - Don Braeger reported the following:

Part C Application – The Department submitted the Part C Application in September. OSEP returned the application on October 25, 2012 requesting additional information, primarily on the system of payments (specifically details about copays and deductibles for public insurance), evaluation and assessment and inclusion of special populations. DDS will resubmit the application to OSEP this month. Don clarified that there is no penalty for not having the application submitted by the original April 16, 2012 deadline and further indicated that he does not anticipate delays in

submitting the APR which is due in February 2013. The Department has approved a face-to-face two day meeting for February.

Department of Social Services-Cheryl Treadwell reported the following:

- Budget Realignment
  A budget of $1.6 billion in child welfare funding was realigned to county social services and funneled into two subaccounts: Behavioral Health and Protective Services. Budget Act 2012 SB 1013 chaptered all of the changes. A fiscal superstructure was created that set up a specific fund, the Local Revenue Fund, which is now the channel through which counties will receive their funding. Counties will now rely 100 percent on taxes and the economy.

  The DSS Adoption District Office feels a direct effect. Some state agency district office adoption functions are shifting to counties that have expressed interest in doing their own adoptions. Some state district offices will continue to do independent adoptions. An official notice will be released when the final decisions are made.

- No bills affecting young children are currently on the House or Senate floor.

- Program Changes
  Katie A., et.al v Bonta Lawsuit affects foster children's receipt of specialty mental health services and creates a system of care for mental health and child welfare services. It includes children that have an open case of supervision at home and in care and entitles them to also receive mental health services that include screening and a referral to link to a provider or to county mental health for further assessment. A practice model must be used that is based on family-centered values of needs, strengths, culture and community.

- New Federal Requirements
  The federal Administration of Children and Families is focusing on promoting the social and emotional well-being of children and youth who have experienced maltreatment and are receiving child welfare services. The shift in focus is intended to provide guidance to states about how to organize activities around meaningful and measurable changes in social and emotional wellbeing for children. States must::
    - Include a description of the activities undertaken by the state to reduce the length of time young children, under the age of five, spend in foster care without a permanent family.
    - Include a description of the activities the state undertakes to address the developmental needs of children under the age of five who receive services.

  - Monitor and treat emotional trauma associated with a child's maltreatment and removal, in addition to other health needs identified through screenings. DSS is partnering with Rady's Children's Hospital in San Diego, which received a federal grant to create a screening and assessment system to pilot a trauma tool for children in foster care with San Diego, Tulare, Mariposa and a fourth county yet to be selected.
  - Implement protocols for the appropriate use and monitoring of psychotropic medications.

- Young Children in Foster Care and the Child Welfare Council
  A white paper is in the final stages of completion for the purpose of framing recommendations and awareness to the Child Welfare Council and public agencies on the importance of early care and early intervention for young children in foster care. The next meeting with the Council's Child and Youth Development subcommittee is December 12, 2012 in San Francisco at the Administrative Office of the Courts. The committee will determine which recommendations to bring forward to the full council at the Child Welfare Council meeting in March. All materials for the December meeting will be posted on the California Health and Human Services Agency's website (www.chhs.ca.gov) under Initiatives.

- Congregate Care Reform
  DSS convened a state work group to address reforming the group home and foster family agency systems to be more performance focused relative to the needs of children, youth and their families. In addition, the work group will design how the program should drive the financing. The goal is to reduce reliance on residential care as a placement but to shift its purpose as a resource in the continuum of care for all children. A legislative report with recommendations is due in 2014.

- Improving the Use of Psychotropic Medication Quality Improvement Project. DSS and Department of Health Care Services have joined forces to implement a project that will address the use of psychotropic medication to address clinical strategies, alternatives to medication, and increase awareness regarding the use and side effects of such drugs on workers, foster families and youth. The kick-off meeting was held on October 29, 2013, where approximately 75 stakeholders came together to set the mission, goals and work group structure in motion. The prevalence of psychotropic use among young children is very small, but it is known that if one is in a group home, one is more likely to be prescribed psychotropic mediations. Anyone interested in joining this effort should contact Cheryl Treadwell at 916-651-6020 or cheryl.treadwell@dss.ca.gov.

Discussions ensued regarding the concern of foster child advocates about oversight for the children and the need for statewide guidance regarding system

planning and quality of care, particularly as they relate to mental health and early brain development. There is currently no state department that coordinates these concerns.

Cheryl expressed that the new federal requirements have prompted a review of all related programmatic pieces, as the federal government is interested in the well-being of children, including a definition of how the state defines well-being. DSS is working closely with its county welfare directors to avoid fragmentation at the local level.

Department of Health Care Services- Galynn Thomas, representing designee Jill Abramson, M.D., reported the following:
DHCS is still working on the Healthy Families transition to Medi-Cal slated for 2013 and is continuing to work on demonstration waivers for California Children's Services (CCS) to be included in managed care plans.

In response to numerous questions and a list of topics in which members are interested, Galynn committed to letting her office know that the ICC has requested a representative from DHCS community mental health to join the Council, and is requesting a name and contact information; and that the ICC requests a presentation on the transition of Healthy Families to Medi-Cal. She will further let the appropriate physician in her Department know that the ICC would also like a presentation on the high-risk infant follow-up program.

Galynn indicated that counties coming up for the transition from Healthy Families to Medi-Cal for the coming year are identified on the DHCS website, http://www.dhcs.ca.gov/Pages/default.aspx (select Hot Topics, then select Healthy Families Program Transition to Medi-Cal) or http://www.dhcs.ca.gov/services/Pages/HealthyFamiliesTransition.aspx.

She also reported, that in its Systems of Care Division, DHCS is continuing to work on the renewal of the Partners for Children 1915-C waiver for home and community-based pediatric palliative care.

Department of Managed Health Care
No report available.

Department of Public Health
Vacant; no report available.

Department of Alcohol & Drug Programs
Vacant; no report available.

Department of Mental Health

Vacant; no report available.

First 5 California
Vacant; no report available.

California Department of Education
Vacant; no report available.

PUBLIC INPUT
Robin Millar, a community representative from Child Development Center, Simi Valley Hospital, congratulated the DDS team on its consistency and resilience in successfully putting together an in-person meeting for February 2013.

Fran Chasen, a community representative from Children's Issues and Answers, Santa Monica, noted an Infant Development Association (IDA) training opportunity on December 7, 2012 at San Fernando Valley Breakfast meeting of the Child Development Institute (CDI). IDA will give an update on the status for early intervention vis-à-vis the recent presidential election and a look to the future with the implementation of California's new budget.

Julie Kingsley Widman, a parent and community representative from HOPE Infant Family Support Program, San Diego County Office of Education, asked whether a phone line could be established at the February meeting for those who cannot attend in person. DDS will investigate and respond to the question in time for the meeting.

SPECIAL PRESENTATION FOR ITCA PARENT LEADERSHIP AWARD
Theresa Rossini, Vice Chair announced that Diane Simon Smith, who was awarded ICC's Parent Leadership Award for 2012, is the recipient of the Infant Toddler Coordinators' Association Parent Leadership Award. Her award was announced at the OSEP Leadership Conference in Washington, D.C. in July 2012. Since she was not able to receive the award in person, we hope to present it to her at the February ICC meeting.

PRESENTATION: PREVENTION RESOURCES AND REFERRAL SERVICES (PRRS)
Susan Roddy, Director of the PRRS, gave an update on the first year of operations which is contracted with the FRCNCA through DDS (Attachment B for PowerPoint).

Cheryl Treadwell is interested in a PRRS presentation for DSS' caregiver network.

In response to questions about how PRRS learns about resources and whether families are satisfied with the services, Susan replied that PRRS is in the midst of an internal evaluation to study comments from phone calls about what is and is not working. They have developed an informational placemat to assist with informing families about PRRS (Attachment C).

Peter Michael Miller offered to introduce PRRS to District IX, which is the official body which represents California's Pediatricians, who are members of the American Association of Pediatrics.

OTHER BUSINESS

Upcoming Proxy Vote on ICC Annual Activities

- Theresa reminded members that the ICC annual activities report that everyone received will be sent via email as an action item for a proxy vote and is due in early December. Every member of the council must respond when the ICC takes a proxy vote by email. In light of that, it was decided that a follow-up email will be sent to those who do not respond. Marie Poulsen will follow-up via phone, with Linda Landry as back-up, for those who are still not responding.

ICC Recruitment

- A discussion ensued regarding current State department vacancies on the ICC. DDS indicated that it is looking at how to address this and collaborating with those departments that have vacancies to see how they can come to the ICC table. It was suggested by ICC members that the ICC send a certified letter to department directors requesting that a designee be appointed to the ICC. Stacie will send an e-mail to the Chairs identifying the appropriate contacts for the certified letters.

- Cheryl commented that the ICC must make the effort to bridge the gaps in relationships that were created when individuals leave the Council. She offered to reach out to CDE's Special Education Division.

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Discussion of format for the February 2013 ICC meeting

The following highlights were discussed regarding format and content for the February 2013 meeting.

- The primary purpose and topic of the meeting will be strategic planning.
- Cheryl Treadwell has agreed to facilitate the strategic planning discussion.
- By January 4, 2013, each committee chair will survey their membership about the issues, topics, and unfinished business they would like to discuss and submit them to DDS who will compile the information and forward to the Executive Committee.
- At the Thursday Executive Committee meeting, members will sort the list in preparation for strategic planning agenda.

- Thursday's Executive Committee meeting will also include strategic planning.
- The Executive Committee pre-meeting conference call the week before the Executive Committee meeting will be reinstated.
- Elaine requested that the SLPA document be submitted as an action item at the February meeting.

Miscellaneous

- The Family Voices webinar is archived on the www.ca.org website.
- It was suggested that DDS send an email to all community representatives to ask whether they are still interested in representing their communities on the ICC.

CLOSING ROLL CALL

WestEd took the closing roll.

ADJOURNMENT

Theresa adjourned the meeting at 10:54 a.m.

OTHER ICC GENERAL MEETING TELECONFERENCE PARTICIPANTS

Friday, November 16, 2012

Community Representatives
Connie Moreland-Bishop
Fran Chasen
Toni Doman
Laurie Jordan
Robin Millar
Peter Michael Miller
Debbie Sarmento
Julie Kingsley Widman

Guests
Susan Roddy, PRRS
Galynn Thomas, DHCS
Marcia Ehinger, M.D., DHCS

Department Liaisons
Michele Donahue
Michael Miguelgorry
Erin Paulsen
Elise Parnes

WestEd
Debbie Benitez
Monica Mathur-Kalluri
Angela McGuire
Stephanie Myers
Virginia Reynolds

ACF Administration for Children and Families	U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES Administration on Children, Youth and Families	
	1. Log No: ACYF-CB-IM-12-04	**2. Issuance Date:** 04/17/2012
	3. Originating Office: Children's Bureau	
	4. Key Words: Social and emotional well-being, trauma, screening and assessment, evidence-based and evidence-informed practices	

INFORMATION MEMORANDUM

TO: State, Tribal and Territorial Agencies Administering or Supervising the Administration of Titles IV-B and IV-E of the Social Security Act, Indian Tribes and Indian Tribal Organizations

SUBJECT: Promoting Social and Emotional Well-Being for Children and Youth Receiving Child Welfare Services

PURPOSE: To explain the Administration on Children, Youth and Families priority to promote social and emotional well-being for children and youth receiving child welfare services, and to encourage child welfare agencies to focus on improving the behavioral and social-emotional outcomes for children who have experienced abuse and/or neglect.

LEGAL AND RELATED REFERENCES: Titles IV-B and IV-E of the Social Security Act; Child Abuse Prevention and Treatment Act; Child and Family Services Improvement and Innovation Act

INFORMATION:

I. Overview

The Administration on Children, Youth and Families (ACYF) is focused on promoting the social and emotional well-being of children and youth who have experienced maltreatment[1] and are receiving child welfare services. To focus on social and emotional well-being is to attend to children's behavioral, emotional and social functioning – those skills, capacities, and characteristics that enable young people to understand and navigate their world in healthy, positive ways. While it is important to consider the overall well-being of children who have experienced abuse and neglect, a focus on the social and emotional aspects of well-being can significantly improve outcomes for these children while they are receiving child welfare services and after their cases have closed. ACYF is organizing many of its activities around the promotion of meaningful and measurable changes in social and emotional well-being for children who have experienced maltreatment, trauma, and/or exposure to violence.

[1] The terms "abuse and neglect" and "maltreatment" are used synonymously in this Information Memorandum.

The child welfare system has made significant strides in recent years. Today, there are 27% fewer children in foster care than there were in 1998 (USDHHS, ACF, ACYF, 2002-2011). There are fewer children entering foster care and more exiting to permanency through reunification, adoption, and guardianship. The system's integration of knowledge about the importance of family connections and stable, nurturing relationships, as well as collaborative efforts among child welfare and other child-serving systems, made these advances possible.

However, there is a growing body of evidence indicating that while ensuring safety and achieving permanency are necessary to well-being, they are not sufficient. Research that has emerged in recent years has suggested that most of the adverse effects of maltreatment are concentrated in behavioral, social, and emotional domains. The problems that children develop in these areas have negative impacts that ripple across the lifespan, limiting children's chances to succeed in school, work, and relationships. Integrating these findings into policies, programs, and practices is the logical next step for child welfare systems to increase the sophistication of their approach to improving outcomes for children and their families.

There is also an emerging body of evidence for interventions that address the behavioral, social, and emotional impacts of maltreatment. By (a) anticipating the challenges that children will bring with them when they enter the child welfare system, (b) rethinking the structure of services delivered throughout the system, and (c) de-scaling practices that are not achieving desired results while concurrently scaling up evidence-based interventions, meaningful and measurable improvements in child-level and system-level outcomes are possible.

Increasing the focus on well-being is not a move away from the child welfare system's essential emphasis on safety and permanency; rather an integrated approach is needed. Policies, programs, and practices can improve children's social and emotional functioning while concurrently working towards goals of reunification, guardianship, or adoption. Addressing the social and emotional elements of functioning for children in foster care can even improve permanency outcomes. For example, a study of adoption recruitment services demonstrated that, in addition to intensive recruitment efforts, ensuring that children receive effective behavioral and mental health services is critical to facilitating a smoother transition to an adoptive home, and can decrease the chances of a disruption of an adoption (Vandivere, Allen, Malm, McKindon, & Zinn, 2011).

II. A Well-Being Framework

There are many frameworks for understanding well-being of children and youth. While these frameworks differ in minor ways, they generally identify similar domains and definitions of well-being. In an effort to understand what well-being looks like and how to support it for young people who have experienced maltreatment, ACYF has adapted a framework by Lou, Anthony, Stone, Vu, & Austin (2008). The framework identifies four basic domains of well being: (a) cognitive functioning, (b) physical health and development, (c) behavioral/emotional functioning, and (d) social functioning. Aspects of healthy functioning within each domain are expected to vary according to the age or developmental status of children or youth.[2] The

[2] Within each developmental category, refinement is possible; for example, for older youth, job readiness and independent living skills are markers of well-being during the transition to adulthood.

framework also takes into account contextual factors, both internal and external to children, that may influence well-being. These include environmental supports, such as family income and community organization, as well as personal characteristics, such as temperament, identity development, and genetic and neurobiological influences. ACYF's framework for well-being is presented in Appendix 1.

Within each domain, the characteristics of healthy functioning relate directly to how children and youth navigate their daily lives: how they engage in relationships, cope with challenges, and handle responsibilities. For example, self-esteem, emotional management and expression, motivation, and social competence are important aspects of well-being that are directly related to how young people move through the world and participate in society.

As was stated above, it is important to attend to the overall well-being of children and youth who have experienced maltreatment. By focusing on social and emotional well-being in particular, ACYF is not de-emphasizing other aspects of well-being. Rather, ACYF is prioritizing social and emotional well-being because: (a) the challenges that children face in these domains are great, (b) there are resources and policies that can be leveraged to improve child functioning in these areas, (c) effective practices and programs for promoting social and emotional well-being are available, and (d) outcomes for children and child welfare systems can significantly improve with an emphasis on social and emotional well-being.

III. Emerging Evidence on the Impact of Maltreatment

Researchers have extensively documented the impacts of abuse and neglect on the short- and long-term health and well-being of children. Emerging evidence demonstrates that these biological and psychological effects are concentrated in behavioral, social, and emotional domains. These effects can keep children from developing the skills and capacities they need to be successful in the classroom, in the workplace, in their communities, and in interpersonal relationships. As a result, this can hinder children's development into healthy, caring, and productive adults and keep them from reaching their full potential. The following points describe some of the impacts of abuse and neglect on children's behavioral, social, and emotional functioning. These findings argue that many of the children involved with child welfare have a set of complex challenges; these challenges may not be addressed by the system and services as they are currently designed. Integrating these recent findings into the design of systems and services will enhance child welfare's ability to improve outcomes for these children and their families.

- **Neurological Impact:** Early childhood is a time of rapid and foundational growth. During this time, the neurological development taking place is building the architecture for the skills and capacities that children will rely on throughout life (National Research Council and Institute of Medicine, 2000).

  Neglect and abuse have distinct effects on the developing brain. During early childhood, neurons are created, organized, connected, and pruned to form the complex workings of the brain. These actions depend, in large part, on the environment in which a young child grows. Neglect (physical, emotional, social, or cognitive) hinders these neurological activities such that the brain does not develop along a normal healthy trajectory towards its full potential.

This negatively impacts a young person's capacity for optimal social and emotional functioning (Perry, 2002).

Abuse has a different, though still harmful impact on neurobiology. Experiences of mild or moderate stress in the context of a secure caregiving environment, such as being temporarily separated from a reliable caregiver or frustrated by the inability to complete a task, support children's development of adaptive coping. Chronic or extreme stress, however, such as maltreatment, has a different result. Children who experience abuse or neglect have abnormally high levels of cortisol, a hormone associated with the stress response, even after they are removed from maltreating caregivers and placed in safe circumstances. Such continuously high cortisol levels adversely affect stress responsiveness, emotion, and memory (National Scientific Council on the Developing Child, 2005). Studies have also shown that heightened stress impairs the development of the prefrontal cortex, the brain region that is critical for the emergence of abilities that are essential to "autonomous functioning and engagement in relationships" (Cook, Blaustein, Spinazzola, & van der Kolk, 2003, p.11). These "executive functions" include planning, focusing, self-regulation, and decision-making. Executive functions are necessary to successfully managing school, work, and healthy relationships.

- **Traumatic Impact:** Traumatic events can elicit mental and physical reactions in children, including hyperarousal and dissociation. If these acute "states" are not treated after children experience trauma, they can become chronic, maladaptive "traits" that characterize how children react in everyday, nonthreatening situations (Perry, 1995).

  Maltreatment is distinct from other types of trauma because it is interpersonal in nature. A caregiver who is supposed to be a secure base-the source of attachment, safety, and security-is also the source of hurt and harm. This creates a confused and ineffective attachment and serves as the model for other significant attachments (Bloom, 1999). Often referred to as "chronic interpersonal trauma" or "complex trauma," maltreatment's impact spans multiple domains, and its severity is further complicated depending on a child's developmental stage. Chronic interpersonal trauma can result in difficulties regulating emotional responses, accurately interpreting the cues and communications of others, managing intense moods (particularly rage and anxiety), regulating arousal states (resulting in dissociation), and accurately forming perceptions of self and others (Terr, 1991). Among children entering foster care in one State, a comprehensive assessment revealed that one in four exhibited trauma symptoms necessitating treatment, including traumatic grief/separation, adjustment reactions, avoidance, re-experiencing, numbing, and dissociation (Griffin, Kisiel, McClelland, Stolback, & Holzberg, 2012).

- **Behavioral Impact:** Whether or not children enter foster care, the prevalence of behavior problems rising to a clinical level[3] is high among children who have experienced maltreatment. The National Survey of Child and Adolescent Well-Being (NSCAW), a longitudinal study of children who were the subject of child protective services reports, provides data to demonstrate this: twenty-two percent of children who remain in their homes

[3] "Rising to the clinical level" describes problems that have been assessed to be severe enough to warrant clinical behavioral health services.

after a report of abuse or neglect have clinical-level behavior problems–the same rate as children who are removed and living with kin. Rates rise to 32% for children living in foster homes and nearly 50% for children in group homes or residential care (Casaneuva, Ringeisen, Wilson, Smith, & Dolan, 2011a).

- **Relational Competence:** Maltreatment also affects the way in which children and youth engage in social interactions and participate in relationships. NSCAW findings indicate that children who are the subject of child protective services reports are twice as likely as children in the general population to have significant challenges in the area of social competence (Casaneuva, Ringeisen, Wilson, Smith, & Dolan, 2011a). The effects of maltreatment can influence relationships across a person's lifetime, impacting the ability to form a new attachment to a primary caregiver, make friends, and engage in romantic or marital partnerships (Mikulincer & Shaver, 2007).

- **Mental Health:** Studies have demonstrated that rates of mental illness are high among children who have experienced maltreatment and have been in foster care. Posttraumatic Stress Disorder (PTSD), Attention Deficit/Hyperactivity Disorder (ADHD), Major Depressive Disorder (MDD), and Conduct Disorder (CD)/Oppositional Defiant Disorder (ODD) are the most common mental health diagnoses among this population. As McMillan, et al. (2005) demonstrated, many children meet diagnostic criteria for these disorders *before* entering foster care, indicating that it is frequently the experience of maltreatment rather than participation in foster care that predicates mental health problems. By the time they are teenagers, 63% of children in foster care have at least one mental health diagnosis; 23% have three or more diagnoses (White, Havalchack, Jackson, O'Brien, & Pecora, 2007).[4]

- **Psychotropics:** According to a 2010 study of Medicaid-enrolled children in thirteen States, children in foster care, who represent only three percent of those covered by Medicaid, were prescribed antipsychotic medications at nearly nine times the rate of children enrolled in Medicaid who were not in foster care (MMDLN/Rutgers CERTs, 2010). Over three years, 22% of children in foster care will have taken a psychotropic drug at some point (Leslie, Raghavan, Zhang, & Aarons, 2010). Data from NSCAW show that rates of psychotropic medication use are comparable for children receiving in-home child welfare services (10.9%), children in kinship care (11.8%), and children in foster care (13.6%) (Casaneuva, Ringeisen, Wilson, Smith, & Dolan, 2011a). Although numerous studies have demonstrated that rates of psychotropic medication prescription are comparatively high, these rates, at least in part, reflect increased levels of emotional and behavioral distress necessitating treatment among this group. More information about the use of psychotropic medications among children in foster care can be found in a related IM issued by the Children's Bureau, ACYF-CB-IM-12-03.

These scientific findings clearly demonstrate the profound impact that maltreatment has on social and emotional well-being. As such, focusing on ensuring safety and permanency alone for children who have experienced abuse or neglect is unlikely to resolve these complex biological

[4] It is important to note that there is significant overlap between mental health and trauma symptoms, and that symptoms of trauma are often mistaken for mental health symptoms (Griffin, Kisiel, McClelland, Stolback, & Holzberg, 2012).

and psychosocial issues. For this reason, child welfare policies, programs, and practices should give greater consideration to explicit efforts to reduce young people's impairment and improve their functioning.

IV. Requirements and Policy Opportunities

Titles IV-B and IV-E of the Social Security Act and the Child Abuse Prevention and Treatment Act (CAPTA) have historically included provisions that promote the well-being of children. Title IV-B programs are intended to enhance the safety, permanence, and well-being of children who are in foster care or are being served in their own homes. The title IV-E foster care program includes requirements to address a child's well-being, such as in the areas of health and education. CAPTA provides funding for prevention, assessment, and treatment programs to increase the well-being and safety of children who have been abused or neglected. Some policy requirements and opportunities in existing policies related to social and emotional well-being are listed below:

- **State Plan for Child Welfare Services (Section 422 of the Social Security Act)** Section 422(b)(15) requires child welfare agencies to develop, in coordination and collaboration with the State title XIX (Medicaid) agency and in consultation with pediatricians, other experts in health care, and experts in and recipients of child welfare services, a plan for the ongoing oversight and coordination of health care services, including mental health services, for any child in a foster care placement.

    - **Mental Health Services:** These health care oversight plans must include a description of how States will provide necessary mental health services to children in foster care. Additionally, States may address the mental health of children who have experienced maltreatment according to provisions elsewhere in statute. For instance, time-limited family reunification services under *Promoting Safe and Stable Families* explicitly include mental health services (431(a)(7)(B)(iii) of the Social Security Act).

    - **Early and Periodic Diagnosis, Screening, and Assessment (EPSDT):** Many States incorporate EPSDT, a standard Medicaid benefit for children and youth, into their health care plans. EPSDT ensures that children get appropriate medical, vision, hearing, and dental check-ups to identify and treat any problems as soon as possible. EPSDT also includes mental health assessments and services. Because they are categorically eligible for Medicaid, all children in foster care who are eligible for title IV-E reimbursement are entitled to EPSDT.

    - **Trauma Screening and Treatment:** 2011's *Child and Family Services Improvement and Innovation Act* requires States to include in their health care oversight plans a description of how they will screen for and treat emotional trauma associated with maltreatment and removal for children in foster care (section 422(b)(14)(A)(ii) of the Social Security Act). Identifying the trauma-related symptoms displayed by children and youth when they enter care is critical for the development of a treatment plan. It is also important to have a complete trauma history for each child. Although children come to the attention of the child welfare system as a result of a specific allegation of maltreatment, abuse and neglect are chronic in nature. Child welfare workers should

have an understanding of the multiple types and incidences of trauma children have experienced, beyond just the event that precipitated child welfare involvement. Conducting comprehensive functional assessments according to a standardized schedule (e.g., every six months, or every time a child moves to a more restrictive placement setting) can help caseworkers and administrators gauge whether or not treatment strategies are working to decrease children's symptoms. States could consider integrating trauma screening into the regular screening activities taking place under EPSDT in order to meet the new requirement.

- **Psychotropic Medication Oversight and Monitoring:** The *Child and Family Services Improvement and Innovation Act* also requires States to submit as part of the health care oversight plans a description of the protocols in place or planned to oversee and monitor the use of psychotropic medications among children in foster care (section 422(b)(14)(A)(v) of the Social Security Act). ACYF, in partnership with the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Centers for Medicare & Medicaid Services (CMS), is currently providing technical assistance to States to support the development of their plans. The recent IM, ACYF-CB-IM-12-06, describes strategies for strengthening systems of oversight and monitoring of psychotropic medications.

  Because use of psychotropic medication with children has not been as extensively tested as use with adults, and because these drugs can have complicated side effects, they should be prescribed with care. When they are prescribed, their use should be justified by clinical evidence identified in EPSDT, trauma screenings, and children's treatment plans. As States develop their plans for prescription psychotropic medication management, there is also work to be done to identify effective psychosocial interventions that can improve behavioral and mental health outcomes of children receiving child welfare services.

- **Child Abuse Prevention and Treatment Act (CAPTA) State Grants:** In order to receive CAPTA funds, States are required to submit a plan that describes how they will support and enhance interagency collaboration among public health agencies, agencies in the child protective service system, and agencies carrying out private community-based programs to improve the health outcomes, including mental health outcomes, of children identified as victims of child abuse or neglect. This includes supporting prompt, comprehensive health and developmental evaluations for children who are the subject of substantiated child maltreatment reports.

  - **Early Intervention:** States receiving CAPTA funds are required to refer children under the age of three with a substantiated case of maltreatment to early intervention services funded under Part C of the Individuals with Disabilities Education Act (§106(b)(2)(B)(xxi)). Children with substantiated cases of maltreatment are assured timely, comprehensive, and multidisciplinary screenings, and, if a developmental disability is identified, they are entitled to ongoing early intervention services. In many States, child-serving systems have worked in collaboration to support early intervention referrals, evaluations, and services for children who have experienced abuse or neglect (Child Welfare Information Gateway, 2007).

Maltreatment impacts how young people form relationships with others throughout their lives. For many maltreated children, nurturing and supportive parental behavior was inconsistent or unavailable, leaving children lacking confidence to explore new environments and relationships (Bretherton, 2000; Sorce & Emde, 1981). States should consider how these policies might best be linked and carried out to support healing and recovery and promote healthy functioning of children and youth.

Other Federal child welfare policies also address elements of well-being, including policies related to kinship care, family connections, sibling placements, monthly parent visits, placement stability, and school stability. When implemented in a purposeful way, these policies all contribute to improving social and emotional well-being, repairing ruptured relationships, and enhancing relational skills.

V. Current State and County Investments

Currently, state and county child welfare systems are investing significant funds in providing services intended to improve well-being outcomes for children and their families. Three of the most common services purchased by states and counties are counseling, parenting classes, and life skills training. However, a number of studies suggest that some of these services are not grounded in the best available evidence and may be provided to children without sufficient attention to their specific maltreatment and trauma histories.

In a study of children receiving mental health services, McCrae, Guo, and Barth (2010) found that children who got typical mental health services had more behavioral problems over time than those who received none. "The study should not be understood to indicate that all [mental health services] for children involved with [child welfare services] are ineffective; rather, it indicates that children [in child welfare] do not predictably receive services that are sufficient to help them overcome their behavioral difficulties" (p.358).

Another study examined interventions to improve caregivers' parenting skills and found "that most of the parent focused interventions currently delivered to families in child welfare and most foster family training do not use treatment strategies with solid empirical support" (Horwitz, Chamberlain, Landsverk, Mullican, 2010, p.28).

Child welfare systems also work to provide youth who are exiting foster care to emancipation with the skills and resources they will need to function as adults. Often this takes the form of programs that teach basic life skills, budgeting and financial management, and health and nutrition. In an evaluation of outcomes for youth in foster care participating in four youth development programs around the country, researchers determined that the life skills training programs studied resulted in no statistically significant improvement on any of the key outcomes measured (Koball, et al., 2011).[5]

[5] These outcomes included: High school completion, current employment, earnings, net worth, economic hardship, receipt of financial assistance, residential instability, homelessness, delinquency, pregnancy, possession of personal documents, any bank account, and sense of preparedness in 18 areas of adult living.

VI. Screening and Functional Assessment

Functional assessment is a central component of promoting social and emotional well-being for children who have experienced abuse or neglect. Traditionally, child welfare systems use assessment as a point-in-time diagnostic activity to determine if a child has a particular set of symptoms or requires a specific intervention. Functional assessment, however, provides a more holistic evaluation of children's well-being and can also be used to measure improvement in skill and competencies that contribute to well-being. Functional assessment—assessment of multiple aspects of a child's social-emotional functioning (Bracken, Keith, & Walker, 1998)—involves sets of measures that account for the major domains of well-being. Rather than using a "one size fits all" assessment for children and youth in foster care, systems serving children receiving child welfare services should have an array of assessment tools available. This allows systems to appropriately evaluate functioning across the domains of social-emotional well-being for children across age groups (O'Brien, 2011). They capture children's strengths, including skills and capacities, as well as potential difficulties (Humphrey, et al., 2011; Roeser, Strobel, & Quihuis, (2002) in a developmentally-appropriate manner, accounting for the trauma- and mental health-related challenges faced by children and youth who have experienced abuse or neglect. Similarly, some assessment tools can be used to measure parenting capacities and improvements over time.

Screening for symptoms related to trauma, specifically how experiences of trauma may impair healthy functioning, is an essential element of functional assessment. Trauma screening involves universal administration of a brief tool(s) to: (1) estimate the prevalence of trauma symptoms and/or traumatic experiences and (2) identify children who may require further assessment and intervention. Examples of trauma screening tools include the Child and Adolescent Needs and Strengths (CANS) Trauma Version, the Childhood Trauma Questionnaire (CTQ), and the Pediatric Emotional Distress Scale (PEDS).

Functional assessment tools can be used to inform decisions about the appropriateness of services. They can be useful tools, for example, for informing the design of outcomes-oriented case plans (Wotring, Hodges, & Xue, 2005). Functional assessments can also track progress toward social-emotional well-being outcomes. Several valid and reliable tools used to measure domains of social-emotional functioning with children and adolescents have been tested and normed with representative samples of children from the general population.[6] Data from these assessments allow States and programs to measure a child's level of functioning and monitor how it compares with general populations of the same age group. In other words, assessment helps systems to determine not only whether a child meets the threshold for a particular concern but also how the child fares relatives to the expected developmental trajectory for child functioning. This allows States and programs to better understand whether interventions are moving each child back on track developmentally within the well-being domains.

Additionally, the universal administration of these types of functional assessment tools to all children in a system at entry and at key follow-up periods can help systems track changes in children's social-emotional functioning compared to their own baseline during and after the

[6] Examples include the Strengths and Difficulties Questionnaire (SDQ), the Child Behavior Checklist (CBCL), the Social Skills Rating Scale (SSRS), and the Emotional Quotient Inventory Youth Version (EQ-i:YV).

delivery of services. This allows systems to generate data that help them understand whether their services are making a positive difference for children and youth. Continuously monitoring progress using these functional assessment tools also helps decision-makers reassess the appropriateness of the service array over time for individual children. Broader analyses of the aggregate data from assessments can help decision-makers at the program and systems levels to identify the best and most effective practices for all children in the target population and for particular subgroups (Wotring, Hodges, & Xue, 2005).

VII. Effective Interventions

Recent research has expanded the knowledge base regarding interventions that treat the behavioral, social, and emotional problems that are common among children who have experienced maltreatment. While generic counseling is not consistently effective in reducing mental health symptoms for children in foster care, several evidence-based treatments have been successful when delivered with fidelity to the model; the same is true for parenting interventions and programs for youth. Many of these interventions have been rigorously tested and shown to reliably improve child functioning by targeting the impact of maltreatment and developing skills and competencies that help children navigate their daily lives. The emergence of promising and effective interventions at multiple levels – at the child level related to trauma and behavioral/mental health; at the older youth level related to relational health and social and emotional –well-being; and at the caregiver level related to increasing capacity to care for their children – provides an opportunity to impact the life circumstances of families as a whole.

Child welfare and mental health systems can develop the capacity to install, implement, and sustain these evidence-based and evidence-informed interventions by using research to identify effective and promising interventions that meet the needs of the specific population to be served; making needed adaptations to bring the interventions to scale within the child welfare system, developing an awareness of principles of evidence-based practices among staff at all levels; and reorganizing infrastructure to support implementation fidelity and further evaluations of these practices and interventions.

Evidence-based and evidence-informed practices have been developed to address the most common mental health diagnoses, trauma symptoms, and behavioral health needs of children and show measurable improvements or promising results.[7] These interventions show measurable improvements or promising results in decreasing emotional/behavioral symptoms; diminishing depression, anxiety; increasing the ability to self-regulate; improving physical health; and helping traumatized children and youth form and maintain healthy attachments. There are also evidence-based and evidence informed interventions geared toward improving outcomes related to youth skill development, education, and employment. (Job Corps and Big Brothers/Big Sisters are examples.) Many of these practices are available but have not been brought to scale or targeted to the foster care population even though they have been shown to improve functioning. Others have shown promising results, and should be evaluated more broadly as they are implemented more widely.

[7] Evidence-based and evidence-informed practices such as Trauma-focused Cognitive Behavioral Therapy, Multisystemic Therapy, and Parent-Child Interaction Therapy are examples. There are also evidence-based and evidence informed interventions geared toward improving outcomes related to youth skill development, education, and employment; Job Corps and Big Brothers/Big Sisters are examples.

It is important to note that many of the evidence-based interventions that improve child functioning require the involvement of caregivers and specifically target their behaviors for change as well. Caregivers need support in managing the behaviors of children who have experienced maltreatment and in providing a nurturing environment in which healing can occur. In such supportive contexts, children can learn "the value, purpose and safety of relationships" (Rees, 2010). In order to achieve better outcomes for children who have experienced maltreatment, it is essential to engage families, whether biological, foster, or adoptive, in the process of healing and recovery.

VIII. Maximizing Resources to Achieve Better Results

By leveraging current policies and requirements and shifting existing resources to promote social and emotional well-being, child welfare systems can begin to align policies, practices, and programs to achieve significantly better results, both for individual children and for the system as a whole.

- **Better Child and Family Outcomes:** Focusing on social and emotional well-being means attending to the specific skills, capacities, and characteristics that children and youth need to develop while they are young in order to be autonomous, healthy adults. Although the impact of maltreatment is pernicious, the experience of abuse and neglect does not guarantee that children will develop the behavioral, psychological, and social-emotional problems listed above. Neither does it mean that children with behavioral concerns, trauma symptoms, and/or mental health disorders cannot heal and recover and become happy, successful adults. By integrating evidence-based and evidence-informed services and supports to promote social and emotional well-being, child welfare systems can help children develop healthy coping mechanisms, relational skills, and the other capacities that they need to succeed in school, to participate in the workforce and their communities, to care for their own children, and to have positive relationships with others.

- **Better System Outcomes:** With services and supports to promote children's social and emotional well-being, system-level outcomes, such as length of stay, congregate care placements, exits to permanency, and reentries, can be expected to improve as well. Children may spend less time in foster care before exiting to reunification, adoption, or guardianship, and reentries into foster care may become less common. While children and youth are certainly not to blame when they do not exit to permanency quickly or when they reenter foster care, children's behavioral problems, when unaddressed, often contribute to placement changes, adoption disruptions, and returns to foster care.

IX. Focusing on Social and Emotional Well-Being

Focusing the work of a child welfare system on well-being, particularly social and emotional well-being, requires a concerted effort on behalf of all staff and stakeholders, from directors, to managers, to supervisors, to caseworkers, to foster parents. It entails (a) understanding the challenges that children who have experienced maltreatment bring with them when they come to the attention of the child welfare system, (b) considering how services are structured and delivered at each point along children's trajectory through the child welfare system, and (c) de-scaling practices that are not improving outcomes while simultaneously installing and scaling up

effective approaches. ACYF recognizes that it is not simple to transform a system in this way and that these processes take time. As the logical next step in reforming the child welfare system, it requires the careful development of capacity to integrate new research and implement new practices without compromising ongoing efforts to achieve safety and permanency for children who have experienced maltreatment.

Understanding Impact of Maltreatment and Anticipating Challenges: As discussed above, maltreatment leaves a particular traumatic fingerprint on the development and functioning of children and youth. Often the behavioral, social-emotional, and mental health problems that children in foster care have are assumed to be the result of their experience with the child welfare system. McMillan, et al. (2005) and Griffin, Kisiel, McClelland, Stolback, & Holzberg (2012) have shown that children and youth frequently display these challenges before they enter foster care.[8] An understanding of the impact maltreatment has had on children when they come to the attention of the child welfare system allows providers to be more proactive, knowing what to look for and anticipating the services that may be needed. This capacity is necessary at the caseworker-level, but also at the level of administrators who are making decisions about the array of services needed internally or through contracts.

Responding and Intervening along the Child Welfare Continuum: Focusing child welfare on improving social and emotional well-being requires careful consideration of how services are structured and delivered throughout the system. For example, a child welfare system with a focus on social and emotional well-being might be characterized by the following:

- Assessment tools used with children receiving child welfare services are reviewed to ensure that they are valid, reliable, and sensitive enough to distinguish trauma and mental health symptoms.
- Children are screened for trauma when their cases are opened.
- In-home caregivers receive services that have been demonstrated to improve parenting capacities and children's social-emotional functioning.
- Child welfare staff and foster parents receive ongoing training on issues related to trauma and mental health challenges that are common among the children and youth being served by the system.
- Assessments take place at regular or scheduled intervals to determine whether services being delivered to children and youth are improving social and emotional functioning.
- Independent living and transitional living programs implement programs to support youth's development of self-regulation and positive relational skills.

De-Scaling and Scaling Up: When child welfare systems make changes, new programs and practices are often added onto the already existing array of services. Ongoing contracts and the need to provide continuous services make it difficult to discontinue or downsize programs that are not improving outcomes for children and youth. Transforming the array of services, rather than simply augmenting it, requires "de-scaling" programs that are not reliably enhancing child functioning by divesting funds and simultaneously shifting resources to support proven practices.

[8] This is not to say that foster care is never detrimental to the well-being of children and youth. However, the fact that children display problems before they come to the attention of the child welfare system indicates that the experience of maltreatment often predicates their difficulties.

Additional dollars may be necessary initially to support installation of evidence-based practices. However, de-scaling programs that are not working and reallocating resources ensures that effective services can be sustained without requiring new, ongoing funding.

Transforming child welfare services by de-scaling and/or converting interventions that are not working while scaling up evidence-based treatments is unquestionably complex and difficult work. Other systems have grappled with this challenge; for example, as mental health services are increasingly provided in community-based settings, the role of residential treatment facilities has been widely reexamined. As new research emerges and the population receiving services changes, it is necessary to reevaluate the way those services are delivered. To start, States can conduct an inventory of the services they are currently providing to children with child welfare involvement and gather information about how effective these services are in improving children's functioning. This information can help drive decision-making about the steps that are necessary to align State, county, and local resources to improve outcomes.

Child welfare agencies that coordinate efforts within and across departments to innovatively re-tool the complement of services available to youth and families in the child welfare system are more likely to achieve sustainable change. Service coordination at the State and local level can benefit from the growing effort across Federal agencies, including the Substance Abuse and Mental Health Services Administration, National Institutes of Mental Health, National Institute on Drug Abuse, Department of Justice, Department of Education, and others, to promote improved well-being outcomes and the use of effective practices.

X. Strategies for Shifting the System to Promote Social and Emotional Well-Being

There are many ways that child welfare systems can begin to embed a focus on social and emotional well-being in their work. A few specific examples are listed below.

Services. This IM has shown that children who have experienced abuse or neglect have significant behavioral, social, and emotional challenges; it has also shown that there are evidence-based practices and interventions that can improve outcomes for children and their families. Delivering effective services is the most critical component of a focus on promoting social and emotional well-being.

- **Screening and Functional Assessment:** Conduct high quality and regular trauma screenings and functional assessments of children, youth, and families to determine exposure to and impacts of maltreatment and other forms of complex interpersonal trauma. The American Academy of Child and Adolescent Psychiatry and the Child Welfare League of America have developed guidelines for screening and assessment to help inform child welfare systems (AACAP & CWLA, 2002). Valid and reliable mental and behavioral health and developmental screening and assessment tools should be used to understand the impact of maltreatment on vulnerable children and youth. Screens and assessments should be sensitive enough to distinguish symptoms of trauma reactions and mental health disorders. The use of such tools is important in fulfilling child welfare agencies' responsibility for ensuring the well-being of children and youth who have been exposed to complex interpersonal trauma (Levitt, 2009). Conducting assessments as early as possible when children become involved with the child welfare system and regularly thereafter allows

caseworkers to know how children are doing initially and whether or not they are getting better with the services provided.

- **Evidence-Based Interventions:** Deliver evidence-based and evidence-informed interventions for the treatment of trauma and mental health disorders. When evidence-based screening and assessment indicates that children are suffering from trauma and/or mental health symptoms, it is necessary to provide treatments that effectively improve functioning. Child welfare systems will need to collaborate with mental health and Medicaid systems to build an array of evidence-based or evidence-informed interventions to improve trauma and mental health-related outcomes for children who have experienced maltreatment.

  In recent years, public and private sector organizations have produced extensive, publically available lists and databases of evidence-based and evidence-informed interventions for improving well-being outcomes for vulnerable children (See "Resources," below). These include, among others, SAMHSA's National Registry of Evidence-Based Programs and Practices (NREPP) and the U.S. Department of Justice's CrimeSolutions.gov. The Agency for Healthcare Research and Quality is currently conducting an evidence review of "Interventions Addressing Child Exposure to Trauma: Child Maltreatment and Family Violence," which will be available later in the year. Additionally, many institutions, including SAMHSA and organizations funded by HHS, including the National Child Traumatic Stress Network (NCTSN) and the National Early Childhood Technical Assistance Center (NECTAC), have published publically-accessible reviews of valid and reliable instruments for screening and assessing various aspects of social-emotional well-being with different populations and age groups. As such, it is now more feasible than ever to identify and implement evidence-based and evidence-informed interventions.

- **Services within Child Welfare:** Consider restructuring services that are the sole responsibility of child welfare. Some services fall completely within the purview of the child welfare system. For example, services provided by Independent Living and Transitional Living Programs are often dictated by the child welfare agency. Others include investigations, case management, and foster parent training. Without requiring the coordination or collaboration of other systems, it may be possible to change the way these services are delivered. Child welfare agencies could redesign programs and modify contracts to require that Independent Living and Transitional Living Programs deliver services that are trauma-informed and evidence based.

Workforce. It is essential to develop a workforce strategy that supports an emphasis on promoting social and emotional well-being. Administrators and staff of child welfare and other systems that affect children receiving child welfare services, including Medicaid, mental health, and the courts must understand the rationale for the focus and have the capacity to implement changes.

- **Capacity around Evidence-Based Practices:** Build the capacity of child welfare and mental health systems' staff to understand, install, implement, and sustain evidence-based practices. This includes: using research to identify effective interventions that improve outcomes for the population; developing an awareness of principles of evidence-based practice among staff at all levels; and reorganizing infrastructure to support implementation

fidelity. While child welfare staff may not be responsible for delivering these interventions, they should be able to appropriately assess and refer children and families to evidence-based treatment providers and determine whether or not the interventions being delivered are having positive effects on child and family functioning. Child welfare workers should also have regular access to learning tools and communities to remain up-to-date on the latest developments in relevant evidence-based practices.

- **Training on Specific Populations:** Train staff to more effectively serve specific populations of children and youth and specific populations of prospective foster and adoptive families served by the child welfare system. While the social and emotional issues of each child differ, certain populations will share common challenges. Lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth are often overrepresented in the child welfare system, and they have a set of unique challenges to overcome (ACYF, 2011). In an earlier IM, States were encouraged to "claim available title IV-E reimbursement for costs associated with training staff to increase their capacity to serve young people who identify as LGBTQ and to consider how the title IV-E agency can best serve young people and keep them safe" (ACYF, 2011, p.2). Additionally, LGBT families can be an untapped resource for placement, and agencies are often working to improve their skills and competencies in serving these families. States may use IV-E training dollars at an enhanced reimbursement rate (75 percent) to improve workers' competency in serving both LGBTQ youth in care and prospective LGBT foster and adoptive families.

- **Training for Professionals Outside of Child Welfare:** Provide training on the impact of maltreatment, trauma, and the social and emotional well-being of children who have been abused or neglected. Under the *Fostering Connections to Success and Increasing Adoptions Act* of 2008, States may use title IV-E training dollars at an enhanced reimbursement rate (75 percent) for training staff of personnel outside of the public child welfare system. Eligible personnel include: staff of private agencies contracted to perform services for the child welfare agency, court personnel, attorneys, guardians ad litem, court appointed special advocates, and prospective relative guardians, as well as foster and adoptive parents.

- **Engaging the Judiciary and the Courts:** The Courts play a critical role in promoting the social and emotional well-being of children known to child welfare. The oversight role of the Courts could be enhanced by providing training on the core components of social and emotional well-being and trauma and effective screening, assessment and intervention approaches that can improve functioning. Judges are well situated to ask questions, ensure effective services are delivered, and track well-being outcomes for their individual cases and at the system level.

System. Promoting social and emotional well-being requires a careful analysis of the way the child welfare system is currently structured and the systemic changes that are necessary.

- **Program Inventory:** Examine current spending to understand where resources can be shifted to support evidence-based programs and practices. Many states are currently purchasing services that are not reliably yielding the desired results, such as generic counseling, parenting classes, and life skills training for emancipating youth. By identifying resources that are being used to support these types of services, child welfare systems can

begin planning to de-scale them and repurpose funds for evidence-based interventions. Ideally, administrators will combine this work with an analysis of data describing the needs of the population of children receiving child welfare services in order to identify areas in which de-scaling and installation of new practices can improve child and family outcomes.

- **Measure Outcomes, Not Services:** It is common for child welfare systems to gauge their success based on whether or not services are being delivered. One way to focus attention on well-being is to measure how young people are doing behaviorally, socially, and emotionally and track whether or not they are improving in these areas as they receive services. At the system level, data from trauma screenings and functional assessments can help administrators understand how successful their child welfare systems are in achieving positive outcomes for children and youth. This understanding can inform decisions about the array of services that is currently available and the procurement of services going forward.

Building a child welfare system that responds effectively to the traumatic impact of maltreatment and promotes social and emotional well-being is complex work. Multiple, complementary strategies must be employed in order to create systematic changes that improve outcomes for children. The progress that the child welfare system has made in recent years has been the result of ongoing and evolving collaborations across multiple child-serving systems, including mental health, Medicaid, education, early childhood, and more. Together, these systems integrated knowledge about the importance of permanency and family connections and structured themselves to deliver services that keep young people safer; keep children with their families more often; and ensure reunification, adoption, and guardianship for more of the children who come into foster care.

As child welfare systems continue to improve and refine their work to promote safety and permanency for children, a strengthened focus on the social and emotional well-being of children who have experienced maltreatment is the logical next step in reforming the child welfare system. Children who have been abused or neglected have significant social-emotional, behavioral, and mental health challenges requiring attention, and treating them with a trauma-focused and evidence-based approach can improve outcomes throughout child welfare. This approach can result in increased placement stability; greater rates of permanency through reunification, adoption, and guardianship; and greater readiness for successful adulthood among all children who exit foster care, especially those youth who leave foster care without a permanent home. Most importantly, it will enable children who have experienced maltreatment to look forward to bright, healthy futures.

XI. Resources

Additional information on the importance of promoting social and emotional well-being and responding to trauma can be found through a number of Federally-funded sources. For example, the National Child Traumatic Stress Network (NCTSN) is a collaboration of academic and community-based centers whose mission is to raise the standard of care and increase access to services for children and their families across the country. NCTSN develops and disseminates evidence-based interventions, trauma-informed services, and educational resources. Additional information on the work of NCTSN can be found on their website: http://www.nctsn.org/.

Several listings include a range of evidence-based and evidence-informed practices to inform child-serving systems about interventions that may be effective in reducing the impact of maltreatment and/or trauma on children in the child welfare system. States should weigh the strength of available evidence in support of the interventions considered.

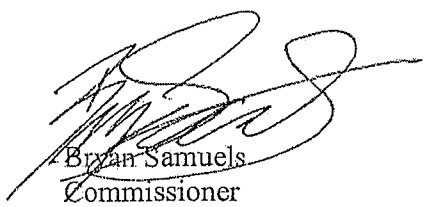
- SAMHSA's National Registry of Evidence-Based Programs and Practices: http://nrepp.samhsa.gov

- *Interventions for Disruptive Behavior Disorders Evidence-Based Practices (EBP) KIT*: SAMHSA's toolkit includes tools to assist in developing mental health programs that help prevent or reduce aggressive behavioral, emotional, and development problems in children by enhancing the knowledge of parents, caregivers, and providers: http://store.samhsa.gov/product/Interventions-for-Disruptive-Behavior-Disorders-Evidence-Based-Practices-EBP-KIT/SMA11-4634CD-DVD

- *Interventions Addressing Child Exposure to Trauma: Part 1-Child Maltreatment*: This comparative evidence review of interventions for children who have experienced maltreatment will be released in summer, 2012 from the Agency for Healthcare Research and Quality (AHRQ). For more information on the project, visit: http://www.effectivehealthcare.ahrq.gov/index.cfm/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productid=846#amendments

In addition, the Child Welfare Information Gateway connects child welfare and other professionals to information and resources to help strengthen families. Information, resources, and tools covering topics within child welfare, out-of-home care, risk and protective factors, and impacts of trauma are readily available through the Gateway for professionals and other individuals wishing to learn more about and improve services for children, youth, and families with child welfare involvement. The Gateway can be accessed through the following website: http://www.childwelfare.gov/.

Inquiries to: Children's Bureau Regional Program Managers



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Appendix 1: ACYF Well-Being Framework

	Intermediate Outcome Domains		Well-Being Outcome Domains			
	Environmental Supports	Personal Characteristics	Cognitive Functioning	Physical Health and Development	Emotional Behavioral Functioning	Social and Interpersonal
Infancy (0-2)	Family income, family social capital, community factors (e.g., institutional resources, collective socialization, community organization, neighborhood SES)	Temperament, cognitive ability	Language development	Normative standards for growth and development, gross motor and fine motor skills, overall health, BMI	Self-control, emotional management and expression, internalizing and externalizing behaviors, trauma symptoms	Social competencies, attachment and caregiver relationships, adaptive behavior
Early Childhood (3-5)	Family income, family social capital, community factors (e.g., institutional resources, collective socialization, community organization, neighborhood SES)	Temperament, cognitive ability	Language development, pre-academic skills (e.g., numeracy), approaches to learning, problem-solving skills	Normative standards for growth and development, gross motor and fine motor skills, overall health, BMI	Self-control, self-esteem, emotional management and expression, internalizing and externalizing behaviors, trauma symptoms	Social competencies, attachment and caregiver relationships, adaptive behavior
Middle Childhood (6-13)	Family income, family social capital, social support, community factors (e.g., institutional resources, collective socialization, community organization, neighborhood SES)	Identity development, self-concept, self-esteem, self-efficacy, cognitive ability	Academic achievement, school engagement, school attachment, problem-solving skills, decision-making	Normative standards for growth and development, overall health, BMI, risk-avoidance behavior related to health	Emotional intelligence, self-efficacy, motivation, self-control, prosocial behavior, positive outlook, coping, internalizing and externalizing behaviors, trauma symptoms	Social competencies, social connections and relationships, social skills, adaptive behavior
Adolescence (14-21)	Family income, family social capital, social support, community factors (e.g., institutional resources, collective socialization, community organization, neighborhood SES)	Identity development, self-concept, self-esteem, self-efficacy, cognitive ability	Academic achievement, school engagement, school attachment, problem solving skills, decision-making	Overall health, BMI, risk-avoidance behavior related to health	Emotional intelligence, self-efficacy, motivation, self-control, prosocial behavior, positive outlook, coping, internalizing and externalizing behaviors, trauma symptoms	Social competence, social connections and relationships, social skills, adaptive behavior
						Social and Emotional Well-Being Domain

PREVENTION RESOURCE AND REFERRAL SERVICES (PRRS)

Talking Points for Regional Center Service Coordinators

Introducing Parents to PRRS:

- Good news! Your child does not need early intervention services. In our community, developmental information and support is available through your local Early Start Family Resource Center (ESFRC) who provides comprehensive information and referrals to community resources which may help you to encourage your child's development. I would like to refer you to them.
- This is an excellent way to stay connected and involved with your child and community services. The ESFRC has been serving families in our community with information, support, resources and referrals for years. They are staffed by parents of children with developmental concerns and have experience accessing and navigating community services.
- ESFRC's offer: Peer parent support, information about community activities and resources that enhances child development, a wealth of information and materials on child development, community service providers, and much more.

If Parents Consent to Referral:

GREAT! I will send the ESFRC your information today. You should hear from them shortly. If you would like to get in touch with them yourself, I'm happy to give you their contact information now.

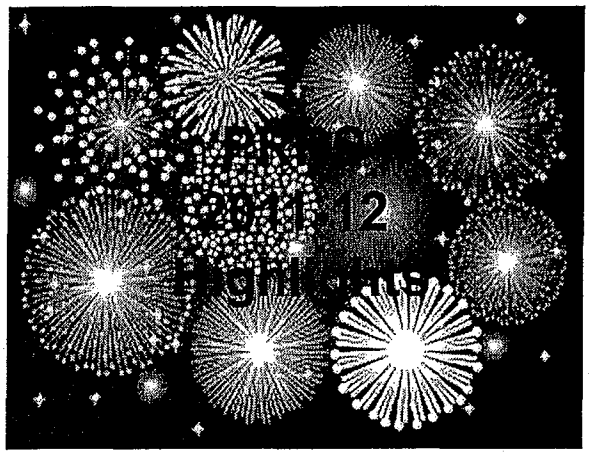
If Parents Decline Referral:

I will put the ESFRC brochure and information about PRRS in the mail for you in case anything changes and you decide you are interested later. You can always get more information on PRRS services by contacting the ESFRC.

Explaining PRRS to Parents:

- PRRS provides enhanced information, resources and referrals to families of babies and toddlers, up to age 3, who are at risk for a developmental delay, but do not qualify for California Early Start. There is no cost for PRRS and it is available statewide.
- The ESFRC will contact you to get started with PRRS. Together, you can identify resources and strategies to encourage your child's development, which you can use as part of your family action plan.
- The ESFRC will keep in touch with you until your child turns 3. If your needs change or concerns arise, they will work with you to access needed information and assistance.

Adapted from materials developed by Exceptional Family Resource Center, San Diego and Imperial Counties, CA

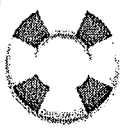


8,915 Individual Family Contacts

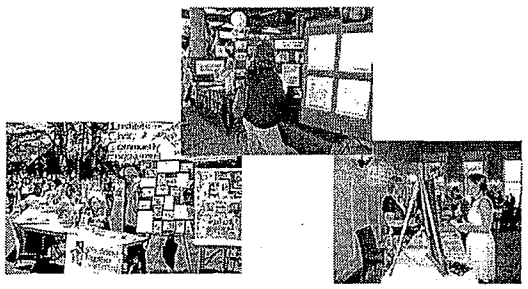


2,300 Families Served

11,751 Types of support, information, resources and referrals




1,110 presentations, exhibits and other outreach activities



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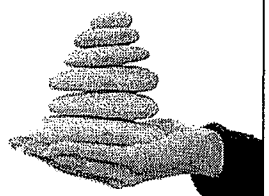
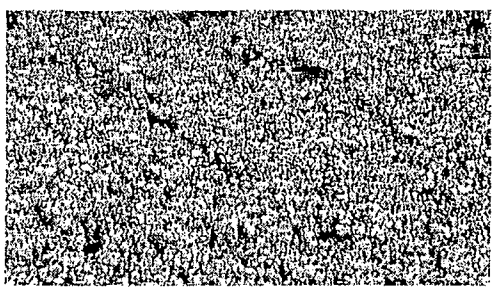


27,169 Parents and professionals received information about PRRS

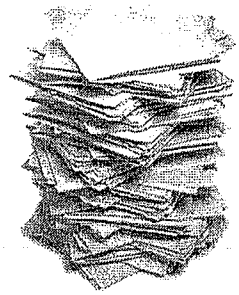


PRRS Staff

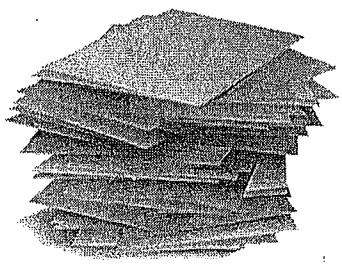
- PRRS Director
- PRRS Fiscal Administrator
- PRRS Data Administrator
- PRRS Coordinator

41 contracts to provide PRRS statewide

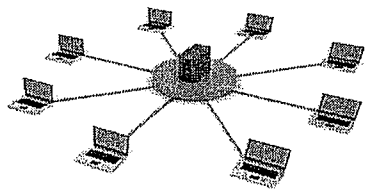
28 PRRS forms and resources available on FRCNCA.org



31 Customizable PRRS documents and brochures in English, Spanish and Chinese

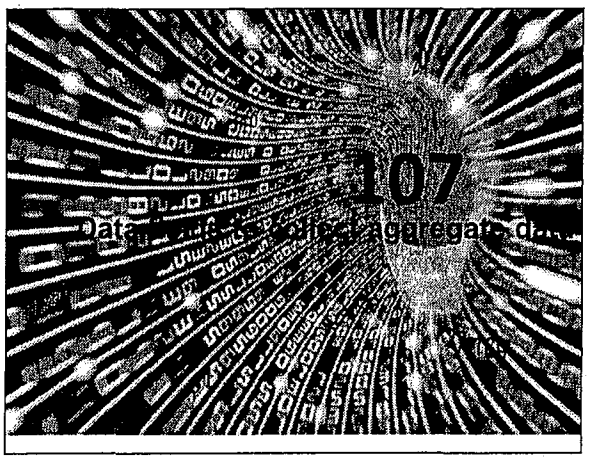


20 Training and technical assistance webinars & conference calls for ESFRC Directors and staff.



PRRS Members-Only webpage

Continue to refer high risk and medically fragile children



For more information please contact

PRRS Director

Susan Roddy

sroddy@frcnca.org

FRCNCA
FAMILY RESOURCE CENTERS NETWORK OF CALIFORNIA

EXECUTIVE COMMITTEE MINUTES & AGENDA

- **AGENDA**
  - ► FEBRUARY 28, 2013

- **JOINT EXECUTIVE & STANDING COMMITTEES MINUTES**
  - ► NOVEMBER 15, 2012

STATE INTERAGENCY COORDINATING COUNCIL
STRATEGIC PLANNING AGENDA

Thursday, February 28, 2013
10:00 a.m. ~ 4:30 p.m.

1. Welcome and Introductions……Theresa Rossini

2. Review Agenda…….....Theresa Rossini

3. Approval of November 15, 2012 EC Minutes…….....…….Theresa Rossini

4. DDS Update……..……..……....Don Braeger

5. Strategic Planning – Unfinished Standing Committee Work Discussion…….Cheryl Treadwell

6. Strategic Planning - ICC Priorities Discussion……..Cheryl Treadwell

7. Lunch……..12:00 pm – 1:30 pm

8. Resume Discussion ……..……Cheryl Treadwell

9. Committee Structure Discussion……..Cheryl Treadwell

10. Other Business……...Theresa Rossini

11. Adjournment (4:30 p.m.)……...Theresa Rossini

DRAFT-TO BE APPROVED

STATE INTERAGENCY COORDINATING COUNCIL
JOINT ICC EXECUTIVE AND STANDING COMMITTEES MEETING

THURSDAY, NOVEMBER 15, 2012

MEMBERS PRESENT

Theresa Rossini,* Acting Chair
Don Braeger
Toni Doman*
Arleen Downing
Gretchen Hester*
Linda Landry*
Marie Kanne Poulsen
Debbie Sarmento*
Elaine Fogel Schneider
Cheryl Treadwell

STAFF

Anastacia Byrne-Reed,* ICC Coordinator, DDS
Angela McGuire,* WebEx Host, WestEd
Carolyn Walker, ICC Recorder, WestEd
Patric Widmann, ICC Supervisor, DDS

OTHERS PRESENT

Refer to Attachment A for a list of other attendees.

*Parent

WELCOME AND INTRODUCTIONS

Theresa Rossini welcomed everyone to the meeting at 1:32p.m.

INITIAL ROLL CALL

WestEd took the roll.

REVIEW EXECUTIVE COMMITTEE AGENDA

The agenda was approved with the following revisions:

- Item 5 is now the Speech and Language Therapy Work Group discussion;
- Item 7 is now the Under Representation and Outreach Work Group discussion;

- Item 8 is now Member Recruitment Summaries;
- The ITCA Parent Leadership Award has been added to Other Business, as has ICC Annual Activities.

APPROVAL OF SEPTEMBER 6, 2012 MINUTES

The minutes were approved with the following corrections:

- The "Standing Committee Strategic Planning" title on page 35 in the ICC packet should read "Standing Committee Reports."
- The second bullet on page 36 should be corrected to read: "For the standard meetings, a two-day meeting is preferable to a one-day meeting."

SPEECH AND LANGUAGE THERAPY (SLT) WORK GROUP

The SLT (work group) sent a draft proposal, for the inclusion of Speech and Language Pathology Assistants (SLPA) in the Early Start system, to ICC members for review. In addition to the work group, members of the Speech, Language and Hearing Association, the director of the Speech and Language Pathology Assistant program at Pasadena City College, individuals from the field in both Northern and Southern California and professionals at DDS and WestEd contributed to the draft proposal. Elaine offered a special thanks to DDS and WestEd for their contributions and support.

Although Title 17 explicitly addresses speech and language pathologists, it does not address SLPAs; a professional level that came into existence after the Title 17 regulations were already in place. Consequently, each regional center interprets the role of SLPAs differently.

To fill the gap and facilitate consistency in the use and work of SLPAs statewide, the draft proposal offers the definition, training requirements , how best practices can be addressed, supervision requirements, licensing issues, and appropriate roles.

The work group will meet in December 2012 and consider dissemination strategies for the document. Final feedback is requested by Friday, November 23, 2012 and Anastacia Byrne-Reed of DDS will resend the draft document to the membership.

The work group will submit the guidelines as an action item at the ICC February 2013 meeting.

DDS STATUS UPDATE

Don Braeger reported on ICC travel and the status of the Part C application to OSEP.

- **ICC Travel Update**
  Don introduced Jim Knight, DDS Assistant Deputy Director, who joined the meeting to discuss ICC travel and face-to-face meetings. Jim explained that although details are still being worked out regarding meeting costs the Department has approved a face-to-face two day meeting in February 2013.

  Jim indicated that the Department would like to see a quorum at the February meeting to ensure that the ICC's business can be accomplished. He said that although a quorum will not be a firm requirement, he would like to ask that the Council get a commitment for attendance at the February 2013 meeting from each of its voting members.

  Jim announced that the Department will research the status of any pending applications that the Department has or should have received to encourage moving them through the process.

A discussion ensued regarding the disposition of current and future travel funds; the status of state agency vacancies in relation to establishing a quorum; ICC members taking responsibility for recruiting and encouraging membership; and the exploring the attendance at previous meetings to better understand availability of funding for future meetings.

The ICC members reiterated a general consensus from the September meeting that Sacramento would be the most practical venue for holding a face-to-face meeting.

- **Part C Application Update**
  DDS submitted the Part C Application to OSEP and has received it back from OSEP requesting more information; primarily regarding the system of payment, and services to special populations.

  Regarding system of payment, Don explained that the trailer bill addressed private insurance, but not public insurance, and that DDS is continuing to work through these issues.

  Regarding special populations, DDS is already serving those populations, infants and toddlers exposed to domestic violence, who are homeless, wards of the court, or are Native American. The Department of Education has a designated staff member who works in the School Turnaround Office, which administrates the Homeless Education Program, and who will may become a state agency representative on the ICC. This effort will be included in the state designee recruitment process. Language that includes this population has been in the regulations since 2004.

Don stressed that there is no penalty or restrictions on funding as a result of submitting the application after the original April 16, 2012, deadline. He further explained that rather than OSEP sending money to the states, the states draw down funds designated to them by OSEP and submit for reimbursement. A state has up to 27 months to submit for reimbursement for any one grant year.

A brief discussion ensued regarding the implications for intervention and outreach, on the part of providers for training. The state addresses these populations through its Child Find activities. Patric Widmann informed the members that DDS is moving in that direction and is already providing training to coordinators of education for homeless children and youth, informing them about referral and outreach materials, such as the brochure ***Reasons for Concern***.

UNDER REPRESENTATION AND OUTREACH WORKGROUP

- **Recruitment Packet Status**
  The Under-Representation and Outreach work group reported that its work is completed thanks to the materials developed by Angela McGuire, Linda Landry, Gretchen Hester and Julie Kingsley Widman. The recruitment packet was disseminated to ICC members and community representatives and is on the DDS website as well.

The group offered some further suggestions:

- The application for community representatives will need updating if the current committee structure changes.
- The first sentence should be changed to make it clear that the application to be a community representative is included in the packet.

Members are encouraged to forward the information to interested parties.

- **Other Recruitment Activities**
  Marie Poulsen will collect the names of representatives in various members' districts.

MEMBER RECRUITMENT SUMMARIES

Marie led a discussion on the need for the proactive recruitment of parents and professionals—particularly those with children under the age of 12, with one parent with a child under the age of 6. in order to be compliant to federal law. All ICC members present reported on their recruitment efforts. The importance of encouraging the Governor's Office to take responsibility for making appointments was stressed. Council members and community representatives made the commitment to contact the state legislators in their districts to request that they contact the Governor's office on behalf of infants and toddlers and their families

in California. Theresa Rossini and Gretchen Hester plan to meet with the Governor's appointment secretary.

Marie has been in contact with the newly formed California Infant Toddler Advocacy workgroup, which identified two Los Angeles State legislators who are infant/toddler advocates—Jimmy Gomez and Christina Garcia. Marie will contact them.

A follow-up action plan includes:

- Marie , Theresa and Arlene Downing will develop and disseminate talking points for use when contacting the State legislators;
- ICC members and community representatives will send the name of the legislator(s) they contact and the legislator's response to Marie so we can map our cumulative effort;
- Stacie Reed will disseminate information on how to access the materials that have been used for our newcomer orientation. The packet can be printed and left with the State legislator's office;
- Gretchen Hester and Theresa will contact the Governor's Office before February and report back to the Council;
- Don will give the ICC feedback on DDS recruitment efforts.

REVIEW NOVEMBER 16, 2012 ICC AGENDA

Action Item 2013 Meeting Dates—Stacie will send an email announcing the proposed meeting dates.

ICC SPECIAL PRESENTATIONS

- University Center of Excellence in Developmental Disabilities at UC Davis Early Intervention Projects (November)—Due to a medical emergency of the presenter, this presentation has been cancelled and will be rescheduled for a future date.
- Speech Therapy Work Group – New—(not addressed)
- 211 Information—(not addressed)
- Resources for Managed Care—(not addressed)

OTHER BUSINESS

- 2012 ITCA Parent Leadership Awardee—Diane Simon Smith, winner of last year's California's ICC Parent Leadership Award will be honored in February 2013 for her ITCA award. This will be formally announced at tomorrow's ICC meeting.
- 2013 California's ICC Parent Leadership Award Application—The application packet was sent to the community; nominations are due December 1, 2012.

- ICC Annual Activities Report 2011–2012—This will be an action item for a proxy vote via email with a deadline in early December. An email will be forthcoming.

CLOSING ROLL CALL

WestEd took the closing roll.

ADJOURNMENT

Theresa Rossini adjourned the meeting at 3:30P.M.

EXECUTIVE COMMITTEE WEBEX MEETING PARTICIPANTS

Thursday, November 15, 2012
10:00A.M. - Noon

COMMUNITY REPRESENTATIVES
Brigitte Ammons
Maurine Ballard-Rosa
Fran Chasen
Laurie Jordan
Robin Millar
Connie Moreland-Bishop
Debbie Sarmento
Sherry Torok
Julie Kingsley Widman

DEPARTMENT LIAISONS
Michael Miguelgorry
Erin Paulsen
Elise Parnes

WESTED STAFF
Monica Mathur-Kalluri
Angela McGuire
Stephanie Myers
Virginia Reynolds

GUESTS
Jim Knight, DDS

STATE OF CALIFORNIA

PART C
ANNUAL PERFORMANCE REPORT SUMMARY
FOR FFY 2011 (2011-2012)

At the time this packet was developed, the Part C Annual Performance Report (APR) was still under the review and approval process by DDS management, and therefore, not ready to be included here. The deadline to submit the APR to the Office of Special Education Programs (OSEP) is February 15, 2013. Upon submission to OSEP, the APR will be made available for review on the Early Start Webpage for your review.

CALIFORNIA
Interagency Coordinating Council on Early Intervention

Together We Make a Difference

ICC ANNUAL ACTIVITIES REPORT FFY 2011-2012

ICC General Meeting Activities	
Action Items-These are items or business that require approval by ICC Members	Action Items • Approved 2011 Annual Activities Report which summarized advice and assistance provided to the lead agency during FFY 2011-2012. • Approved the ICC meeting dates for 2012. • Family Resource Center Network of California granted voting membership by the Council.
Public Input	Public input was received from parents, professionals and/or others interested in early intervention services. Input was documented and can be found in the ICC minutes. Public input trends were analyzed and presented to the ICC for consideration.
Family Resource Centers Network of California (FRCNCA)	• Reported quarterly on various statewide family support activities. • Reported quarterly on Prevention Resource & Referral Service (PRRS) activities.

ICC General Meeting Activities (Continued)	
State Agency Reports on fiscal and program policies affecting young children	Agency reports centered around the budget crisis and the potential impact on services for young children. Details are available in the ICC minutes.
Special Presentations	The following presentations were made to the ICC: • *Through Your Child's Eyes: American Sign Language*-Presented by Nancy Sager, CDE. • *Center for Social & Emotional Foundations in Early Learning*-Presented by Linda Brault, *New Part C Regulations*-Presented by Jeannie Smalley, DDS. • *Part C Annual Performance Report (APR) FFY 2010*-Presented by Erin Paulsen, DDS. • *A Tour of the Early Start Report*-Presented by Michele Donahue, DDS. • *Office of Homeless Education*-Presented by Leanne Wheeler, CDE.
2011 ICC Parent Leadership Award - Annual recognition by the ICC of individuals who make a difference in their Early Start community.	The recipient of the 2011-2012 ICC Parent Leadership Award was Diane Simon Smith. Ms. Smith is a family therapist from Woodland Hills, CA, who specializes in marriage and family counseling to those families with infants and toddlers with developmental disabilities. She is also the parent of two adult sons with developmental disabilities This unique blend of professional and personal expertise made Ms. Smith the outstanding candidate for the award.

CALIFORNIA INTERAGENCY COORDINATING COUNCIL ON EARLY INTERVENTION
Annual Activities for FY 2011-2012

"Together We Make A Difference"

Executive Committee Activities	
Specific Priorities developed by the ICC over the course of FFY 2011-2012 included a combination of unfinished work from the FFY 2010-2011 strategic planning year and new items developed in FFY 2011-2012.	Priority areas: • Data Collection and Analysis. • Child & Family Outcomes. • Issues: Transition, Natural Environments, Surrogacy. • Comprehensive System of Personnel Development • ICC Recruitment. • New Part C Regulations.
Strategic planning for Standing Committees-On 10/28/2012, the new Part C Regulations were released. The ICC discussed strategic items related to the current state of the ICC.	Identification of strategic items: • ICC outreach & recruitment needs. • Development of Speech and Language Pathology Assistant work group and best practices guidelines. • Restructuring of the standing committees to accommodate relevancy.
Other Business	Discussion & Activities: • Under Representation & Outreach Work Group made the following recommendations: ○ Appointed new ICC members and community representatives. ○ Added language to by-Laws addressing required attendance/participation. ○ Facilitate public input/participation… ○ Addressed barriers to/provide supports for participation.

Standing Committee Activities	

Policy Topics Committee (PTC)	Discussions & Assignments:
	• Developed the draft document, *Guidance for Early Start Service Coordinators to Request Authorization for Private Insurance*. This draft document was developed to provide guidance to service coordinators at the regional centers in assisting families in obtaining authorization from their (private) insurance companies for payment of Early Start services. In the future, the document will be expanded upon to include a guide for parents and other individuals. This draft document is currently under review. Discussed strategies for disseminating information about the new PRRS to the community.
	• Developed 3-5 strategic items for ICC to focus on in FFY 2011-2012:
	  ○ Recommended development of best practices guidance for regional centers on the appropriate use of Speech & Language Pathology Assistants (SLPAs)
	  ○ Recommended recruitment strategies of parents to serve as members on the ICC.
	  ○ Recommended review of new Part C regulations and the potential impact on the draft document: *Guidance for Early Start Service Coordinators to Request Authorization for Private Insurance.*

Standing Committee Activities (Continued)	

Child & Family Outcomes Committee (CFOC)	Discussions & Assignments:
	• Continued focus on the following indicators to augment Annual Performance Report (APR):
	  ○ Indicator 4 (Family Outcomes)
	  ○ Indicator 7 (Timely Evaluation & Assessment)
	  ○ Indicator 13 (Mediation Agreements)
	• Recommended that the Family Resource Center Network of California (FRCNCA) become a voting member on the Council.
	• Administrated Parent Leadership Award application process and selection of 2011 ICC Parent Leadership Award to Diane Simon Smith.
	• Reviewed recruitment & retention of ICC parent involvement and identified recruitment strategies.
	• Continued review of two programs serving the birth to three population, Prevention Program and PRRS.
	• Recommended that clarification be developed on the issue of consents governing the educational rights of children as they enter the foster care system.
	• Provided feedback on the ICC Annual Activities Report for FFY 2010.

Standing Committee Activities (Continued)	

Quality Data Committee (QDC)	Discussions & Assignments
	• Reviewed complaints and mediation (Indicators 10 & 13) from APR. Reviewed data trends to ascertain possible reasons for hearings.
	• Reviewed data trends surrounding PRRS.
	• Reviewed Early Start Report as a data source for the APR.
	• Review of diagnostic categories which qualify a child for Early Start services to formulate ideas about possible trends that exist in the data presented.
	• Viewed presentation by John Redman, DDS, who discussed the data collection methods used to build supporting data for APR Indicators 10 (Complaints) and 13 (Mediation).
	• Discussed new strategic items of ICC recruitment and development of Speech & Language Work Group.
	• Continued focused review of APR Indicators which govern social and emotional development:
	  ○ Indicator 1 (Timely Services)
	  ○ Indicator 7 (Timely Evaluation & Assessment)
	  ○ Indicator 8 (Transition)
	• Reviewed Early Start Report in light of what is

Standing Committee Activities (Continued)	
Quality Data Committee (QDC)-Continued	currently being offered in training and technical assistance needs and how feedback can be included in on-line training courses and institutes. • Reviewed and analyzed how the monitoring process has been modified with the advent of the Early Start Report. • Reviewed and provided feedback on draft ICC Public Input form.

Qualified Personnel Committee (QPC)	Discussions & Assignments:
	• Reviewed ongoing responsibilities related to Comprehensive System of Personnel Development:
	  • Viewed and provided feedback on presentation by Angela McGuire, WestEd, on newly developed *Early Start Foundations*, an institute for participants of online training.
	  • Recommended that infant/family mental health be considered for online training.
	• Reviewed and summarized monitoring reports in light of what is currently being offered in training and technical assistance, and how feedback can be included in on-line training courses and institutes.

Standing Committee Activities (Continued)	
Qualified Personnel Committee (QPC)-Continued	• Reviewed and summarized public input in light of what is currently being offered in training and technical assistance, and how feedback can be included in on-line training courses and institutes. • Discussed strategies to recruit ICC nominees and encourage Governor to make appointments • Reviewed and provided feedback on the draft ICC Public Input form. • Reviewed Early Start Report. • Reviewed and questioned how the monitoring process has been modified with the advent of the Early Start Report

Priorities, Outcomes, And Recommendations

Interagency Coordinating Council on Early Intervention
1600 Ninth Street, Room 330, Sacramento, CA 95814
(916) 653-4017 · FAX (916) 654-3255 · TDD 654-2054

February 17, 2009

Rick Ingraham, Part C Coordinator
Children and Family Services Branch
Department of Developmental Disabilities
1600 9th Street, Room 330
Sacramento, CA 95814

Dear Mr. Ingraham,

Enclosed are the State Interagency Coordinating Council on Early Intervention (ICC) 2008 Priorities, Outcomes, and Recommendations to the Department of Developmental Services (DDS) approved at the ICC meeting on November 21, 2008.

In January 2006, the ICC identified four areas of priority using input from parents and families, our professional partners, and the Lead agency to address community needs. The priority areas were assigned to the four ICC standing committees to develop recommendations for system improvements with measurable outcomes. The Committee assignments were as follows:

1. *Outreach to health care professionals* – Public Awareness Committee
2. *Social, emotional and behavioral well-being of young children and their families* – Quality Service Delivery Systems Committee
3. *Special health care needs/managed care* – Integrated Services and Health Committee
4. *Supports for young children and their families in natural environments* – Family Resources and Supports Committee

During the past three years, Committee members reviewed and analyzed extensive data on the Early Start service system and considered the needs of infants, toddlers and their families to develop the twenty (20) recommendations. We hope that our work will be useful to DDS in making policy decisions and system changes. We look forward to continuing to work with you and your staff to enhance and improve California's Early Start program.

Sincerely yours,

Mac

RAYMOND M. PETERSON, M.D.
ICC Chairperson

Enclosure

cc: ICC members

INTERAGENCY COORDINATING COUNCIL ON EARLY INTERVENTION 2008 PRIORITIES, OUTCOMES AND RECOMMENDATIONS

Priority: ***Outreach to Healthcare Professionals*** *(*Public Awareness Committee)

Measureable Outcome: Early Start products and materials will increase access to support services as evidenced by increased early and appropriate referrals by targeted health care providers to regional centers, local education agencies and family resource centers.

ICC Recommendation #1: The Interagency Coordinating Council (ICC) recommends that a dissemination plan with strategies for local level distribution be developed by the Department of Developmental Services (DDS), with input from the Public Awareness Committee (PAC), for distribution of The Primary Health Care Provider's Role in Early Intervention brochure and other Early Start materials to address potential referral sources that may be under-identifying young children, specifically those between 12-24 months of age.

ICC Recommendation #2: The Interagency Coordinating Council (ICC) recommends that the Department of Developmental Services (DDS) provide ongoing reports and/or data to the Public Awareness Committee (PAC) such as WestEd product dissemination, information from monitoring visits, child find efforts, primary referral sources, physician referrals, percentages served, languages spoken, Baby Line calls and other information to identify promising early entry strategies for program improvements.

ICC Recommendation #3: The Interagency Coordinating Council (ICC) recommends that the State of California home page and websites at partner State Departments and other entities, including but not limited to, Head Start/Early Head Start, regional centers and local education agencies, have a link to the Early Start home page housed on the Department of Developmental Services (DDS) website with a clear message that also identifies Early Start, specifying the age range from birth-3 years.

ICC Recommendation #4: The Interagency Coordinating Council (ICC) recommends that the Public Awareness Committee (PAC) be responsible for reviewing all Early Start outreach products and activities and advising the Department of Developmental Services (DDS) regarding the content and dissemination of future public awareness materials and child find efforts to ensure maximum benefits from all public awareness and child find efforts unless the Office of Special Education Programs (OSEP) mandates preclude the Committee review.

ICC 2008 RECOMMENDATIONS continued

Priority: ***Supports and Services to Enhance Social, Emotional, and Behavioral Development of Children Birth to Three and Their Families*** (Quality Service Delivery Systems Committee)

Measureable Outcome: To ensure that parental concerns regarding the social, emotional and behavioral development of their infants and toddlers are appropriately addressed, the QSDS Committee recommends that by 2010, 100% of children's records reviewed through ES monitoring will show that 1) service providers/coordinators recognize social-emotional-behavioral concerns that have been identified through family interview and a norm-referenced screening or assessment tool implemented upon referral and annually throughout the period of eligibility for Early Start service, and 2) service providers/coordinators appropriately respond to the concerns that have been identified.

ICC Recommendation #5: The Interagency Coordinating Council (ICC) recommends that the Department of Developmental Services (DDS) identify and evaluate reliable and appropriate screening and assessment tools, i.e., norm-referenced and focused on young children, birth-3, with disabilities or at-risk conditions, that address social, emotional and behavioral development of infants and toddlers.

ICC Recommendation #6: The Interagency Coordinating Council (ICC) recommends that the Department of Developmental Services (DDS) supports the infusion of Core Provider infant family mental health competencies, as identified in the ICC's recommended 2008-09 Early Start Personnel Model (ESPM) revision, into Early Start Comprehensive System of Personnel Development (CSPD) training institutes. Curriculum content on social-emotional-behavioral development will include 1) How to provide anticipatory developmental guidance, and 2) How to recognize and respond to social, emotional and behavioral concerns.

ICC Recommendation #7: The Interagency Coordinating Council (ICC) recommends that the Department of Developmental Services (DDS), with the assistance of the ICC, design and pilot a profile of local partner agency services and supports relating to screening, referral, intervention, and treatment offered to families who express concern regarding the social, emotional, and behavioral development of their infants and toddlers.

ICC Recommendation #8: The Interagency Coordinating Council (ICC) recommends that the Department of Developmental Services (DDS), in conjunction with the ICC, collect and disseminate strategies to cross-train state and local Early Start partner agencies about services and supports available for parents who express concerns about the social, emotional, and behavioral development of their infants and toddlers.

ICC Recommendation #9: The Interagency Coordinating Council (ICC) recommends that the Department of Developmental Services (DDS) compile and track data about social-emotional and behavioral functioning via processes such as Early Start monitoring, for example, add item/s to self-review, record review checklists, and establish baseline, and/or analyze/track progress.

ICC Recommendation #10: The Interagency Coordinating Council (ICC) recommends that the Department of Developmental Services (DDS), in coordination with the Quality Services and Delivery Systems (QSDS) Committee and the Public Awareness Committee (PAC), collaborate

with the First 5 Association to review and disseminate the California Early Childhood Social-Emotional Health System Development Project workgroup materials for appropriate use by Early Start.

ICC 2008 RECOMMENDATIONS continued

Priority: ***Special Health Care Needs/Managed Care*** **(**Integrated Services & Health Committee**)**

Measurable Outcome: Improve access to health care and early intervention services for eligible infants and toddlers with special health care needs by ensuring that A) Reasons for delays in timely service provision for children with special health care needs enrolled in managed care programs are identified and resolved, B) Records reviewed during monitoring indicate that strategies to support parent participation in activities designed to enhance their ability to meet their child's developmental needs, including respite, are discussed and included in the IFSP and that indicated service authorizations are present, C) Enhanced promotion of training opportunities, information and resources related to the inclusion of children with special health care needs targeted to early care and education providers as evidenced through TTAC minutes, D) All children referred with hearing loss will have an eligibility determination for Early Start within 45 days of referral, and E) All ES service coordinators receive comprehensive local or regional training/workshops on comprehensive health status review practices and procedures within 18 months of hire date.

ICC Recommendation #11: The Interagency Coordinating Council (ICC) recommends that the Department of Developmental Services (DDS) promote as best practice that the Early Start agencies develop or update coordination plans to increase the number of designated liaisons across the system who interface regularly with 1) Fee-for-Service Medi-Cal and Medi-Cal Managed Care providers, and 2) Local managed care collaborations focused on health care issues (i.e., roundtables, case conferences, etc.).

ICC Recommendation #12: The Interagency Coordinating Council (ICC) recommends that care coordination plans be utilized to 1) Document (e.g., survey) conflicts and delays in service provision during previous fiscal year (baseline), 2) Document activities (care coordination agendas/minutes/interagency agreements, etc.), 3) Self-monitor progress (service implementation dates following referral, changes in local procedures, etc.), and 4) Facilitate comprehensive exchange of information between Early Start agencies and Health Care providers (i.e., timely sharing of medical records and Individualized Family Service Plans to Primary Health Care Providers).

ICC Recommendation #13: The Interagency Coordinating Council (ICC) recommends that the Department of Developmental Services (DDS) request that the Training and Technical Assistance Collaborative (TTAC) identify options for training to early care and education providers in order to promote inclusive practices for children with special health care needs.

ICC Recommendation #14: The Interagency Coordinating Council (ICC) recommends that a regional pilot effort be initiated for establishing a data collection methodology to be developed with the Department of Developmental Services (DDS), the California Department of Education (CDE), and the Department of Health Care Services (DHCS) for establishing a baseline and for collecting and tracking referral and eligibility information on children who are identified as having hearing loss and are referred for Early Start services, including 1) Date of referral, 2) Date of eligibility determination, 3) Reasons for delays in eligibility determination, and 4) Documentation regarding children lost to the system following referral.

ICC 2008 RECOMMENDATIONS continued

ICC Recommendation #15: The Interagency Coordinating Council (ICC) recommends that as an additional option to attending Early Start Institutes, Early Start Comprehensive System of Personnel Development (CSPD) local training grants be marketed to encourage local collaborative training on health status review practices and procedures to include 1) Utilizing Early Start Service Coordinator's Handbook, Section 11, The Health Status Review, 2) Performing and documenting a comprehensive health status review, 3) Utilizing the Health Status Review as a service coordination tool, 4) Identifying health-related service and support needs, 5) Developing health-related service and support outcomes, 6) Collaborating strategies, 7) Appropriately utilizing Generic and Other health care service providers, 8) Exchanging information with providers (e.g., Individualized Family Service Plan sent to the Primary Health Care Provider), and 9) Outreach to and disseminating information to the medical community.

ICC Recommendation #16: The Interagency Coordinating Council (ICC) recommends that agencies coordinating local or regional trainings/workshops on comprehensive health status review practices and procedures, publish local training timetable, curricula, and attendance for review and confirmation during monitoring.

ICC 2008 RECOMMENDATIONS continued

Priority: ***Supports for Children and their Families in Natural Environments as indicated by the Individualized Family Service Plan*** (Family Resources & Supports Committee)

Measurable Outcomes: Early Intervention agency staff and families will have increased access to information on respite as a family support service provided through California Early Start and the regional center system;

Families will have the opportunity to discuss awareness of respite service and use and Service Coordinators will demonstrate increased ability to assess families' respite needs; and

Alternative methods of distributing the Service Coordinator's Handbook will be implemented.

ICC Recommendation #17: The Interagency Coordinating Council (ICC) recommends that respite information be included in, but not be limited to, the Early Start Institutes, Service Coordinator's Handbook, Family Resource Centers Network of California (FRCNCA) resources, Regional Center Resources, and Family Support Guidelines.

ICC Recommendation #18: The Interagency Coordinating Council (ICC) recommends that detailed information about the different types of respite services be included in the Service Coordinator's Handbook as part of family support services (information may include Respite Issue paper, evidence-based practice, existing information at the local level and other pertinent information as deemed necessary).

ICC Recommendation #19: The Interagency Coordinating Council (ICC) recommends that the Department of Developmental Services (DDS) continue to pursue alternative ways to distribute the Service Coordinator's Handbook via website and online trainings.

ICC Recommendation #20: The Interagency Coordinating Council (ICC) recommends that Early Start focused monitoring activities and other varied activities (i.e., National Center for Special Education Accountability and Monitoring [NCSEAM], surveys, phone calls, etc.) review the assessment of the families' concerns, priorities, and resources to assess knowledge of respite and the usage of respite services in Early Start. This process shall include parents, Service Coordinators, and Early Start Family Resource Centers.

TRAVEL FORMS

STATE OF CALIFORNIA – PERSONNEL ADMINISTRATION

TRAVEL EXPENSE CLAIM

STD. 262 (REV. 7/2005)

*See Instructions and *Privacy Statement On Reverse Side*

Page 1 of 1 Pages

CLAIMANT'S NAME	SSN or EMPLOYEE NUMBER*	DEPARTMENT
		Developmental Services

POSITION	CB/ID No.	DIVISION or BUREAU	INDEX NUMBER
ICC		CSSD/CFSB/ICC	9232

RESIDENCE ADDRESS *			HEADQUARTERS ADDRESS		TELEPHONE NUMBER
			1600 9TH STREET, RM 330		(916) 654-1596
CITY	STATE	ZIP CODE	CITY	STATE	ZIP CODE
			SACRAMENTO	CA	95814

(1) MONTH/YEAR (2) DATE	TIME	(3) LOCATION WHERE EXPENSES WERE INCURRED	(4) LODGING	(5) MEALS BREAK-FAST	LUNCH	O.T., L/T, N/C, RELO. OR DINNER	(6) INCIDEN-TALS	(7) TRANSPORTATION (A) COST OF TRANS.	(B) TYPE USED	(C) CARFARE, TOLLS, PARKING	(D) PRIVATE CAR USE MILES	AMOUNT	(8) BUSINESS EXPENSE	(9) TOTAL EXPENSES FOR DAY
												0.00		0.00
												0.00		0.00
												0.00		0.00
												0.00		0.00
												0.00		0.00
												0.00		0.00
												0.00		0.00
												0.00		0.00
												0.00		0.00
												0.00		0.00
												0.00		0.00
												0.00		0.00
(10) SUBTOTALS			0.00	0.00	0.00	0.00	0.00	0.00		0.00	0	0.00	0.00	0.00
COLUMN CODE (ACCTG. USE ONLY)														
CLAIM TOTAL														0.00

(11) PURPOSE OF TRIP, REMARKS AND DETAILS (Attach receipts/vouchers when required)

TO ATTEND ICC MEETING IN _____

ON THE FOLLOWING DATE(S) _____

CLAIMANT IS AN: ___ICC MEMEBER ___PARENT SERVING

IN AN ADVISORY CAPACITY AS REQUIRED UNDER PART C OF IDEA

(12) NORMAL WORK HOURS: 8am-5pm

(13) PRIVATE VEHICLE LICENSE NUMBER:

(14) MILEAGE RATE CLAIMED: 0.565

AGENCY ACCOUNTING OFFICE USE ONLY

PAID BY REVOLVING FUND CHECK NUMBER

(15) I HEREBY CERTIFY That the above is a true statement of the travel expenses incurred by me in accordance with DPA rules in the service of the State of California. If a privately owned vehicle was used, and if mileage rates exceed the minimum rate, I certify that the cost of operating the vehicle was equal to or greater than the rate claimed, and that I have met the requirements as prescribed by SAM Sections 0750, 0751, 0752, 0753 and 0754 pertaining to vehicle safety and seat belt usage.

CLAIMANT'S SIGNATURE	DATE	(16) SIGNATURE OF OFFICER APPROVING TRAVEL AND PAYMENT	DATE

(17) SPECIAL EXPENSE AUTHORIZATION - SIGNATURE and TITLE *(See Item 17 on reverse)* | DATE

STATE OF CALIFORNIA – PERSONNEL ADMINISTRATION

TRAVEL EXPENSE CLAIM

STD. 262 (REV. 7/2005)

INSTRUCTIONS

Expense accounts are to be submitted at least once a month and not more often than twice a month, except where the amount claimed is less than $10, the claim need not be submitted until it exceeds $10 or until June 30, whichever occurs first. Requests for reimbursement of out-of-state travel expenses must be claimed separately. Requests for reimbursement of travel expenses which are incurred in different fiscal years must be claimed separately. A brief statement, one line if possible, of the purpose or objective, of the trip must be entered on the line immediately below the last entry for each trip. If the claim is for several trips for the same purpose or objective, one statement will suffice for those trips. Vouchers which are required in support of various expenses must be arranged in chronological order and attached to the claim. Each voucher must show the date, cost, and nature of the expense.

MULTIPLE PAGES–If your claim is more than one page, indicate page number and total number of pages. DO NOT total each page. Use subtotals and enter the total amount of the claim on the last page of the claim in the space for "TOTALS" and "CLAIM TOTAL."

COLUMN ENTRIES

(1) MONTH/YEAR–Enter numerical designation of month and last two digits of the year in which the first expenses shown on the form were incurred.

(2) DATE/TIME–Enter date and time of departure on the appropriate line using twenty-four-hour clock (example: 1700 = 5:00 p.m.). Show time of departure on date of departure, show time of return on the date of return. If departure and return are on the same date, enter departure time above and return time below on the same line. Where the first date shown is a continuation of trip, enter "Continuing" above that date, and where a trip is continuing beyond the last date shown, write "Continuing" after the last date.

(3) LOCATIONS WHERE EXPENSES WERE INCURRED–Enter the name of the city, town, or location where expenses were incurred. Abbreviations may be used.

(4) LODGING–Enter the actual cost of the lodging in accordance with and not to exceed the maximum amount authorized by current Department of Personnel Administration (DPA) regulations and bargaining agreements. A receipt is required for any lodging expense.

(5) MEALS–Enter the actual cost of each meal not to exceed the maximum amount for each meal as authorized by current DPA regulations and in accordance with bargaining agreements. Dinner column is to be used to claim dinner on regular travel, overtime meals, and long term and relocation daily meal expenses. Receipts for meals must be maintained by the employee as substantiation that the amount claimed was not in excess of the amount of actual expense.

OVERTIME MEAL AND BUSINESS RELATED MEAL–Enter the actual cost of the meal not to exceed the maximum amount authorized by current DPA regulations, and bargaining agreements. Refer to DPA Management Memos for receipt requirements.

(6) INCIDENTALS–The term incidentals includes, but is not limited to, expenses for laundry, cleaning and pressing of clothing, and fees and tips for services, such as for porters and baggage carriers. It does not include taxicab fares, lodging taxes or the costs of telegrams or telephone calls. Enter the total actual cost of incidentals not to exceed the maximum amount authorized by current DPA regulations and agreements.

(7) TRANSPORTATION–Purchase the least expensive round-trip or special rate ticket available. Otherwise the difference will be deducted from the claim. If you travel between the same points without using round-trip tickets, an explanation should be given.

(A) COST OF TRANSPORTATION–Enter the cost of purchased transportation. Show how transportation was obtained if fare was not purchased for cash. Use "CC" for credit card and "C" for cash. If transportation was paid by the State, enter method of payment only. Use "SCC" for State credit card, "TO" for ticket order or "BSA" for billed to State agency. Attach all passenger coupons and ticket order stubs including the unused portion of tickets, other credit documents or premiums, where credits or refunds are due to the State.

(B) TYPE OF TRANSPORTATION USED–Enter method of transportation used. Use "R" for railway, "B" for bus, airporter, light rail, or BART, "A" for scheduled commercial airline, "RA" for rental aircraft, "DA" for department-owned aircraft, "PA" for privately owned aircraft, "PC" for privately owned car, truck or other privately owned vehicles, "SV" for specially equipped vehicle for the handicapped, "SC" for State vehicles, "RC" for rental vehicles, "T" for taxi, and "BI" for bicycle. Supervisors shall not authorize the use of motorcycles on official State business, and no reimbursement will be allowed for motorcycles.

(C) CAR FARE, TOLLS, AND PARKING–Enter streetcar, ferry, local rapid transit, taxi, shuttle or hotel-bus fares, bridge and road tolls, and parking charges; attach a voucher for any parking charge in excess of $10.00 for any one continuous period of parking and each item of expense in this item.

(D) PRIVATE CAR USE–Enter number of miles traveled and amount due for mileage for the use of privately owned automobiles as authorized by current agreements and DPA regulations 599.631.

(8) BUSINESS EXPENSE–Claims for phone calls must include the place and party called. If charge exceeds $5.00, support by vouchers or other evidence. Emergency purchases of equipment, clothing or supplies, travel expenses of inmates, wards, or patients of institutions, and all other charges in excess of $1.00 require receipts and an explanation.

(9) ENTER TOTAL EXPENSES FOR DAY

(10) ENTER SUBTOTALS OR TOTALS

(11) PURPOSE OF TRIP, REMARKS OR DETAILS–Explain need for travel and any unusual expenses. Enter detail or explanation of items in other columns, if necessary. Vouchers must be provided for any miscellaneous item of expense.

(12) NORMAL WORK HOURS–Enter your beginning and ending normal work hours using twenty-four-hour clock (example: 0800 = 8:00 a.m.).

(13) PRIVATE VEHICLE LICENSE NUMBER–Enter license number of the privately owned vehicle used on official State business. To claim reimbursement, you must have met the requirements as prescribed by SAM Sections 0751, 0752 and 0753 pertaining to operator requirements, vehicle safety, seat belt usage and authorization.

(14) MILEAGE RATE CLAIMED–Enter the rate of reimbursement being claimed for private vehicle use. Rate will not exceed rate established in contracts and DPA rule 599.631

(15) CLAIMANT'S CERTIFICATION AND SIGNATURE–Your signature certifies that expenses claimed were actually incurred as a result of conducting state business and that the cost of operating the vehicle is at or above the rate claimed.

(16) SIGNATURE OF OFFICER APPROVING PAYMENT–Certifies and authorizes travel; approves expenses as incurred on State business.

(17) SIGNATURE OF AUTHORITY FOR SPECIAL EXPENSES–When a claim for conference or convention expense under Sections 599.635 and 599.635.1 of the DPA regulations and detailed in SAM Section 0724 is included, or when reimbursement of a business expense exceeds $25.00 or when reimbursement for Bar dues or license fees is included, the signature of the approving officer is required, either on a separate document attached to this claim or by signature in this block.

* PRIVACY STATEMENT

The Information Practices Act of 1977 (Civil Code Section 1798.17) and the Federal Privacy Act (Public Law 93-579) require that the following notice be provided when collecting personal information from individuals.

AGENCY NAME: Appointing powers and the State Controller's Office (SCO).

UNITS RESPONSIBLE FOR MAINTENANCE: The accounting office within each appointing power and the Audits Division, SCO, 3301 C Street, Room 404, Sacramento, CA 95816.

AUTHORITY: The reimbursement of travel expenses is governed by Government Code Sections 19815.4(d), 19816, and 19820. These sections allow the Department of Personnel Administration (DPA) to establish rules and regulations which define the amount, time, and place that expenses and allowances may be paid to representatives of the State while on State business.

PURPOSE: The information you furnish will allow the above-named agencies to reimburse you for expenses you incur while on official State business.

OTHER INFORMATION: While your social security account number (SSAN) and home address are voluntary information under Civil Code Section 1798.17, the absence of this information may cause payment of your claim to be delayed or rejected. You should contact your department's Accounting Office to determine the necessity for this information.

WORKSHEET FOR CLAIMING TRAVEL EXPENSES

This form is for identifying the travel expenses for which you are claiming reimbursement. Complete this form, sign the Travel Expense Claim – STD 262 (on the last line of the form) and provide the last four digits of your social (top of the form), **leave the rest of the form blank**, and submit both forms to Patric Widmann, Department of Developmental Services, Children & Family Services Branch, Interagency Coordinating Council, 1600 Ninth Street, Room 330, Sacramento, CA 95814. Reimbursement for expenses is limited to the amounts and by the conditions specified in the Summary of Allowed Travel Expenses which you have received. We will complete and submit your Travel Expense Claim form based on the information you provide. Please include Travel Claim Expense form with **original** signature and the last four digits of your social security number. Please attach all original receipts (including airline itinerary) except those incurred for meals (keep those for your records).

ICC Member Completes:

Left Home: _____
Date Time am / pm (circle one)

Returned: _____
Date Time am / pm (circle one)

PLEASE ATTACH **ORIGINAL** RECEIPTS

Airline Receipt **(RECEIPT REQUIRED, even if prepaid)** PREPAID BY ICC/DDS_____ PAID_____ (check one)	$
Miles Traveled by Own Car _____ at 0.565 cents per mile	$
Car Rental Receipt **(RECEIPT REQUIRED, even if prepaid**) PREPAID BY ICC/DDS_____ PAID_____ (check one)	$
Lodging Receipt **(must have original lodging receipt with a "0" balance)**	$
Taxi or Shuttle (over $10.00, include receipts)	$
Parking and Bridge Tolls (over $10.00, include receipts)	$
Child Care Receipt (ICC parent representative)	$
Miscellaneous Expense (need receipt[s])	$

MEALS (NO RECEIPTS NEEDED)

DATE	BREAKFAST ($6)	LUNCH ($10)	DINNER ($18)	MEAL TOTALS
	$	$	$	$
	$	$	$	$
	$	$	$	$

EXPENSE GRAND TOTAL **$**

_____ _____ _____
ICC Member Name Print or Type last four of SSN# Signature

_____ _____
Telephone Car License Plate Number

_____
Street Address City State Zip Code

_____ _____
Location of Meeting Purpose of Meeting

INTERAGENCY COORDINATING COUNCIL ON EARLY INTERVENTION
SUMMARY OF ALLOWED TRAVEL EXPENSES

ICC Members will be reimbursed for the actual cost, up to the maximum allowance, for each meal, lodging, and incidental expense for each complete 24 hours of travel. Original receipts with zero balance are required to substantiate actual lodging expenses.

The State of California has policies and regulations regarding expenditure of state funds on travel, which includes transportation, meals, and lodging. The following are the allowances and travel reimbursement rates approved by the Department of Personnel Administration. **If in doubt about any expense, consult with ICC Staff Manager prior to incurring expense.**

MEALS

It is important to remember there are **NO FLAT RATE** reimbursements. All meals claimed are to be for the actual amount of expense, up to the maximum allowed. Since no provision requires submission of meal receipts, it is the traveler's responsibility to retain receipts and other records of expense in case of an audit. **No lunch or incidental may be claimed on trips of LESS than 24 hours.**

BREAKFAST	Up to $6.00	May be claimed for a trip that begins at or before 6:00 a.m. and ends after 8:00 a.m.
LUNCH	Up to $10.00	May be claimed for a trip that begins at or before 11:00 a.m. and ends at or after 2:00 p.m. on the following day.
DINNER	Up to $18.00	May be claimed for trips that begin at or before 5:00 p.m. and end at or after 7:00 p.m.
INCIDENTALS	Up to $6.00	May be claimed for trips over 24 hours.

LODGING

Travel must be 50 miles or more from home to claim lodging expense.

MOST COUNTIES IN CALIFORNIA	Actual cost of lodging up to $84.00 per night, plus taxes. Requires submission or receipt.
LOS ANGELES AND SAN DIEGO COUNTIES	Actual cost of lodging up to $110.00 per night, plus taxes. Requires submission of receipt.
SAN FRANCISCO, SAN MATEO, SANTA CLARA, AND ALAMEDA COUNTIES	Actual cost of lodging up to $140.00 per night, plus taxes. Requires submission of receipt.

TRANSPORTATION

Please choose the most economical method of travel. A personal car or rental car may be used in lieu of other transportation options if it is more cost effective.

Any use of a rental car requires prior authorization by the ICC Staff Manager.

AIRLINE	All flights are booked thru Southwest Airlines. Privately arranged airline travel to and from the meeting will be reimbursed for actual costs, up to a maximum of the cost of state contracted airline travel. **Southwest air flights must be arranged according to SWABIZ procedures**. Please contact ICC Coordinator for more information.
PERSONAL CAR	Actual mileage to and from the meeting will be reimbursed at 0.565 cents per mile with the maximum allowance up to the cost of state contracted airline transportation. Your automobile license number will need to be listed on your travel claim form. Actual mileage to and from the airport will be reimbursed at 0.565 cents per mile.
TAXI/SHUTTLE SERVICE	Fare plus 15% tip is allowed. Requires submission of original receipt.
CAR RENTAL	Actual rental cost, with original receipt, is reimbursed with prior approval. No reimbursement will be made for the purchase of a damage waiver (collision insurance) or "PEC" (Personal Effects Coverage). Gas reimbursed with original receipt.
PARKING	Receipts are required for reimbursement of any amount over $10.00. **Airport parking cannot exceed the economy, long term rate.**

GENERAL TRAVEL ARRANGEMENTS

ICC Members must arrange airline travel through www.swabix.com or by calling (800) 435-9792. Please submit your travel needs no later than three weeks prior to the ICC meeting. You will need the following information:

- Your name and fax number
- State that you are traveling under Department of Developmental Services/Interagency Coordinating Council
- Billing Code 86232
- Destination details

It is not necessary to show the airfare cost on your travel worksheet for travel arranged through STS, however you must submit your itinerary with your Travel Expense Claim.

CHILD CARE REIMBURSEMENT

ICC Members who are a parent of a child with special needs may claim reasonable childcare costs for meeting attendance by submitting a signed receipt (including child's name, dates, number of hours and cost per hour) from the provider.

TRAVEL ADVANCES

Travel advances are available to ICC Members by contacting the ICC Coordinator Anastacia Byrne-Reed at (916) 654-1590 or AReed2@dds.ca.gov Advances may be used to secure your room deposit as well as other travel expenses. Please request a travel advance no later than three weeks prior to travel to allow time for processing and mailing of the advance to you. Travel advances **must be cleared within two months of use** by submitting a travel expense claim or remitting payment for the remaining balance. Following the meeting, a Travel Expense Claim must be submitted to clear the advance before another advance can be issued.

SWABIZ

Effective July 1, 2006, Southwest Airlines (SWA) will no longer provide contracted fares through travel agencies. Therefore, in order to receive the state contracted fares, SWA flight reservations cannot be made through Sacramento Travel Agency and must be made online. The SWA website for making reservations is www.SWABIZ.com or call Toll Free 800/435-9792.

To make online reservations, each traveler must establish a Rapids Reward Account before a reservation can be made. The Rapid Rewards number is 214/792-4223.

Instructions for STD. 236 Hotel/Motel Transient Tax Waiver

Fill out the attached Use STD. 236 to get your Hotel/Motel Transient Occupancy Tax Waived. Please note that not all hotel motel-operators will honor this form as they are not mandated to do so.

Print or type in the following fields

- Date
- Hotel/Motel Name
- Hotel/Motel Address
- Occupancy Dates
- Amount Paid
- Traveler's Name
- Executed At
- Traveler's Signature
- Date Signed

Provide Hotel/Motel Operator with a copy for their records.

If you should have any questions, please call Patric Widmann at 916/654-3722 or Anastacia Byrne-Reed at 916-/654-1596.

STATE OF CALIFORNIA

HOTEL/MOTEL TRANSIENT OCCUPANCY TAX WAIVER (EXEMPTION CERTIFICATE FOR STATE AGENCIES)

STD. 236 (NEW 9-91)

HOTEL/MOTEL OPERATOR: RETAIN THIS WAIVER FOR YOUR FILES TO SUBSTANTIATE YOUR REPORTS. PARTICIPATION BY OPERATORS IS STRICTLY VOLUNTARY

DATE EXECUTED

HOTEL / MOTEL NAME

TO: HOTEL / MOTEL ADDRESS *(Number, Street, City, State, ZIP Code)*

This is to certify that I, the undersigned traveler, am a representative or employee of the State agency indicated below; that the charges for the occupancy at the above establishment on the dates set forth below have been, or will be paid for by the State of California; and that such charges are incurred in the performance of my official duties as a representative or employee of the State of California.

OCCUPANCY DATE(S)

AMOUNT PAID

$

STATE AGENCY NAME

HEADQUARTERS ADDRESS

TRAVELER'S NAME *(Printed or Typed)*

I hereby declare under the penalty of perjury that the foregoing statements are true and correct.

EXECUTED AT: *(City)* , CALIFORNIA

TRAVELER'S SIGNATURE

DATE SIGNED